Welcome

to Absolute Total Care!

Dear Absolute Total Care Member,

Thank you for choosing Absolute Total Care as your South Carolina Medicaid health plan. You became an Absolute Total Care member because you live in our service area* and are eligible for the South Carolina Healthy Connections Medicaid Program. Absolute Total Care is a plan that gives you choices – from choosing your primary care provider (PCP) to participating in special programs that help you stay healthy.

Please check the Absolute Total Care member identification (ID) card(s) that you received as a new member to make sure they are correct. If you find a mistake, please call Member Services at 1-866-433-6041 (TTY: 711). We will change it for you. Be sure to bring your Absolute Total Care member ID card and Medicaid ID card with you when you see your doctor. Also, bring them with you when you go to the hospital or pharmacy. Keep these cards in a safe place.

If you have not chosen a PCP for yourself and your family, please choose one now. You may call Member Services at 1-866-433-6041 (TTY: 711) and choose a PCP over the phone, or you can select a new PCP in the mobile app or in the Secure Member Portal found at absolutetotalcare.com.

Please read this Member Handbook and keep it handy. It tells you about your benefits and who to call when you have questions.

Sincerely,

Absolute Total Care

*Please check our website at absolutetotalcare.com for a current map of our service area or refer to the map following this page in the handbook.

***Revision Date**: October 2026*

Notice of Non-Discrimination

Absolute Total Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity). Absolute Total Care does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity).

Absolute Total Care:
Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- **Qualified sign language interpreters**
- **Written information in other formats (large print, audio, accessible electronic formats, other formats)**

Provides free language services to people whose primary language is not English, such as:

- **Qualified interpreters**
- **Information written in other languages**
- **If you need these services, contact Member Services, by mail at: 100 Center Point Circle, Suite 100, Columbia, SC 29210; by phone at: 1-866-433-6041 (TTY: 711); or by email at: ATCMBRSVC@centene.com.**

If you believe that **Absolute Total Care** has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity), you can file a grievance with:

1557 Coordinator
PO Box 31384, Tampa, FL 33631
855-577-8234 (TTY: 711)
FAX: 866-388-1769
SM_Section1557Coord@centene.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our **1557 Coordinator** is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at https://www.hhs.gov/ocr/complaints/index.html

This notice is available at **Absolute Total Care's** website:
https://www.absolutetotalcare.com/members/medicaid/nondiscrimination-notice.html

Language Assistance

Language assistance services, auxiliary aids and services, larger font, oral translation and other alternative formats are available to you at no cost. To obtain this, please call 1-866-433-6041 (TTY: 711).

Language Services

If your primary language is not English, language assistance services are available to you at no cost. Call: 1-866-433-6041 (TTY: 711).

Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-433-6041 (TTY: 711).

أذا كانت لغتك الاساسية غير اللغة الانكليزية فان خدمات المساعدات اللغوية متوفرة لك مجانا.اتصل على الرقم:

1-866-433-6041(رقم هاتف الصم والبكم 711)

Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-866-433-6041 (TTY: 711).

Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-433-6041 (телетайп: 711).

Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-433-6041 (TTY: 711).

Se você fala português do Brasil, os serviços de assistência em sua lingua estão disponíveis para você de forma gratuita. Chame 1-866-433-6041 (TTY: 711)

如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-866-433-6041 (TTY: 711)

Falam tawng thiam tu na si le tawng let nak asi mi 1-866-433-6041 (TTY: 711) ah tang ka pek tul lo in na ko thei.

धयद आप हदी बोलते ह तो आपके िलए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह। 1-866-433-6041 (TTY: 711) पर कॉल कर।

한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-433-6041 (TTY: 711)번으로 전화해 주십시오.

Haka tawng thiam tu na si le tawng let asi mi 1-866-433-6041 (TTY: 711) ah tang ka pek tul lo in ko thei.

Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-433-6041 (ATS: 711).

နမ့်ကတိၤ ကညီ ကျိာ်အယိ, နမၤန့် ကျိာ်အတၢ်မၤစၢၤလ၊ တလာ်ဘူဉ်လာ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လိၤ. ကိး 866-433-6041 (TTY: 711)

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-866-433-6041 (መስማት ለተሳናቸው: 711).

အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့် ှင့်အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် 1-866-433-6041 (TTY: 711) သို့ ခေါ် ဆိုပါ။

absolute total care | Healthy Connections

Map of Counties Served



Counties approved

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IMPORTANT RESOURCES

Notice

Do you need this book translated? Do you need help understanding this book? If you do, call Member Services at 1-866-433-6041 (TTY: 711). To get this information in paper form, in large font, in other languages or as an audio CD free of charge, call Member Services. We will send a paper form of this book to you within five business days of your request.

Statement of Understanding

This is your Absolute Total Care Member Handbook and has information that explains how Absolute Total Care works. Please review the information and keep it handy for future reference. This handbook was designed to help guide you through Absolute Total Care's system. Please take time to review it carefully. Make sure both you and your family understand your benefits before a time arises when you may need to use them. Keep this handbook in a safe place.

Please take time to review and understand these important benefit documents. Information about Absolute Total Care's structure, operations, service utilization policies, and physician incentive plans is available upon request.

THIS HANDBOOK IS NOT A CERTIFICATE OF INSURANCE AND SHALL NOT BE CONSTRUED OR INTERPRETED AS EVIDENCE OF INSURANCE COVERAGE BETWEEN THE CONTRACTOR AND THE MEMBER.

Interpreter and Translation Services

Interpreter services are provided free of charge to you. This includes sign language. Absolute Total Care has a telephone language line available 24 hours a day, seven days a week. We can help you talk with your provider when another translator is not available.

Here is what to do when you call Absolute Total Care:

- Call Member Services at 1-866-433-6041 (TTY: 711).
- Tell them the language you speak. We will make sure an interpreter is on the phone with you.

Here is what to do when you call a provider's office to make an appointment:

- Tell them you need help with translation. You should also tell them what language you speak. We will make sure you get help at your visit.
- If you have any problems getting a translator, please call Member Services.

Changes in Law

Any changes in law shall be reflected in the member handbook as soon as possible but no later than ninety (90) calendar days after the effective date of the change.

Important Phone Numbers

If you have any questions, Member Services will help you. Our normal business hours are 8 a.m. to 8 p.m. Eastern Standard Time (EST), Monday through Friday. If you would like to speak with a nurse, the Nurse Advice Line is available 24 hours a day, seven days a week.

Contact	Phone
Member Services	1-866-433-6041 Fax: 1-866-912-3610 TTY: 711
South Carolina Relay Services	Voice: 1-800-735-2905 TTY: 1-800-735-8583
24/7 Nurse Advice Line	1-866-433-6041
To Change Your Doctor	1-866-433-6041
Vision Services	1-866-433-6041
Dental Services* (provided by DentaQuest)	1-888-307-6553
Pharmacy Services	1-866-433-6041
Start Smart for Your Baby® (Start Smart)	1-866-433-6041
Language Assistance	1-866-433-6041
Non-Emergency Transportation Services* (provided by ModivCare)	1-866-433-6041*

*Covered by Medicaid Fee-for-Service

If You Are Hearing, Speech, or Sight Impaired

Are You Hearing, Speech, or Sight Impaired?

If so, we can help you.

- For Absolute Total Care telecommunications device calls, call 711.
- For South Carolina Relay service calls, call 711 or 1-800-735-8583 (TTY), or 1-800-735-2905 (Voice).

Absolute Total Care also has audio CDs for members who cannot see well. If you need help in person, we can visit you at your home or in our office.

Your Member Identification (ID) Card

Always carry your Absolute Total Care member ID card with you. Show it every time you get care. You may have problems getting care or prescriptions if you do not have it with you. If you have other health insurance cards, bring them with you. Each family member will also receive a state Medicaid ID card. Always carry both cards at all times. Remember to show your Medicaid ID card for items not covered by Absolute Total Care. The ID cards can only be used by the member whose name is on the card. Do not let anyone else use your card. If you do, you may be responsible for their costs.

Absolute Total Care Member ID Card:

Front

1. Absolute Total Care and Healthy Connections Logo
2. Member Name
3. Member ID
4. PCP Name
5. PCP Phone Number
6. Pharmacy Information

Back

7. Emergency Phone Number
8. Important Phone Numbers
9. Absolute Total Care Billing Address
10. Absolute Total Care Website



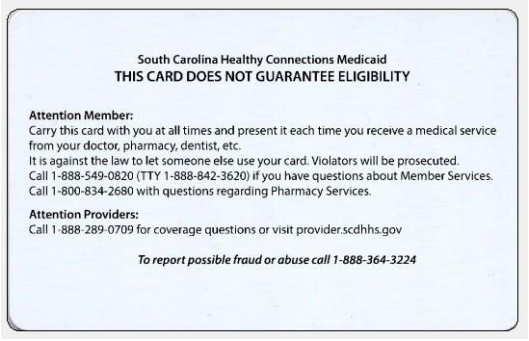


State Medicaid ID Card:

Front



Back



Member Services

Our Member Services staff are ready to help you get the most from Absolute Total Care. The Member Services Department will tell you how Absolute Total Care works and how to get the care you need. Calls received after business hours are routed directly to the nurse advice line. We are here to help you 24 hours a day.

Member Services can help you with the following:

- PCP changes
- Lost ID cards
- Change of address
- Benefit questions
- Appropriate utilization of services
- How to access services
- How to get medical advice when you cannot see the doctor
- Access to out-of-plan care
- Emergency care and urgent care
- Process for prior authorization of services
- Explanation of medical information release authorizations
- Other healthcare questions you may have

Member Services:
Phone: 1-866-433-6041
TTY: 711
8 a.m. to 8 p.m. (EST)
Monday – Friday
Closed on federal holidays

Fax: 1-866-912-3610

Email: ATCMBRSVC@centene.com
Website: absolutetotalcare.com

You may also write us at:
Absolute Total Care
100 Center Point Circle, Suite 100
Columbia, SC 29210

Members can reach the Care Management, Pharmacy, and Quality Improvement (QI) Departments using the Member Services phone, fax, email, and address above.

Website Resources

Absolute Total Care's website helps you find answers. The website has resources and features that make it easy to get quality care. Visit absolutetotalcare.com to access the website resources below:

- Member Handbook and forms
- Facts about Absolute Total Care's programs
- Benefits and services
- Newsletters

Secure Member Portal

Absolute Total Care's Secure Member Portal is a convenient and secure tool to assist you. Go to absolutetotalcare.com to create your online account. Creating an account is free and easy.

By creating an account, you can:

- Change your PCP
- Request a new member ID card
- Update your personal information

- Check your My Health Pays™ rewards balance
- Send us a message

Mobile App

Absolute Total Care's mobile app is a convenient and secure tool to assist you. Use the QR codes below or Go to the Apple or Google app store and search for "Health Insurance Portal." The app and account are free.

App Store Google Play

Once you log into the app, you can:

- Change your PCP
- Request a new member ID card by mail
- Save and share a digital ID card
- Find a provider
- Send us a secure message
- Connect to pharmacy, health plan and authorization information, and more

Find a Provider Tool

As an Absolute Total Care member, you can choose who you see for your healthcare needs from any of our network of providers. Our website also features a Find a Provider Tool, which helps you search for a doctor by name, location, or specialty. Using the Find a Provider Tool will help you find information about network providers such as:

- Name, address, and phone numbers
- Languages other than English
- Professional qualifications
- Specialties
- Board certifications
- Accepting new patients

Call Member Services at 1-866-433-6041 (TTY: 711) for more information about a provider's medical school and residency. You can visit our website at https://findaprovider.absolutetotalcare.com/location to find a provider or call Member Services at 1-866-433-6041 (TTY 711) to request a printed copy of the provider directory.

Please note: Some providers may choose not to perform certain services based on moral or religious grounds. Members can obtain counseling or referral services from any other network provider. Call Member Services at 1-

866-433-6041 (TTY: 711) if you need assistance locating another provider. Absolute Total Care does not restrict services, including counseling or referrals for moral or religious objections.

Nurse Advice Line

Our nurse advice line is ready to answer your health questions 24 hours a day, seven days a week. The nurse advice line is staffed with registered nurses. These nurses have spent a lot of time caring for people. They are ready and eager to help you. To reach the nurse advice line, call 1-866-433-6041 (TTY: 711) and select "Member Services", then "Nurse Advice Line".

The services listed below are available by contacting the nurse advice line:

- Medical advice line
- Health information library
- Help in determining where to go for care
- Answers to questions about your health
- Advice about a sick child
- Information about pregnancy

Not sure if you need to go to the emergency room?
Sometimes you may not be sure if you need to go to the emergency room. The nurse advice line can help you decide where to go for care. Emergency services are services for a medical problem that you think is so serious that it must be treated right away by a doctor.

Major Life Changes

If you have a major change in your life, your South Carolina Healthy Connections caseworker needs to know. If you have any changes to your income, resources, living arrangements, family size, physical or mailing address, county of residence or anything else that might affect your case (for example, a child moved out or spouse went to work), you must report these changes to your local Medicaid eligibility office right away. To do this, call 1-888-549-0820.

You may also find your county office by visiting the website www.scdhhs.gov and clicking on "Getting Medicaid," then clicking "Where to Go for Help."

Transition of Care

If you are new to Absolute Total Care, we will make sure you continue to get the services you need. One of the most common obstacles to switching Medicaid plans is maintaining your relationship with the physicians that know you best. Our staff will work with you and your doctors to continue any services you are receiving even if the doctor is not in our network.

It is important to let us know right away if you are getting services and information that you need to continue receiving the healthcare you need on our Medicaid Managed Care plans or so that we can assist you with transitioning to a new provider.

We provide you with the information you need on how to become familiar with Absolute Total Care and continue receiving the services you need.

We will honor your previous health plan's authorized services for 90 days after coming onto our plan. After that time, we may require authorization for the service. We will let you stay with an out-of-network doctor until you are able to find a doctor in our network that can provide the services you need. Our Care Managers can help get your medical records transferred to your new doctor.

If you are transitioning from Absolute Total Care, we will comply with requests from your new plan and/or SCDHHS for necessary documentation to support your transition and continuity of care.

If you have questions about transitioning your care, call Member Services at 1-866-433-6041 (TTY: 711).

PRIMARY CARE PROVIDER (PCP)

What Your Primary Care Provider (PCP) Will Do for You

Your PCP is a doctor you see on a regular basis to take care of your medical needs. You do not have to go to the emergency room for basic medical care. You can call your PCP when you are sick and do not know what to do. Do not wait until you are sick to meet your doctor for the first time. Seeing your doctor for regular checkups helps you find problems early enough to fix them. Your PCP should be able to provide all your primary care.

Your PCP will:

- Make sure that you receive all medically necessary services in a timely manner.
- Follow up on the care you receive from other medical providers.
- Take care of referrals for specialty care and services offered by Medicaid.
- Provide ongoing care.
- Update your medical record, which includes keeping track of the care that you get from other physicians and specialists.
- Accept you as a patient, unless the office is full and closed to all new patients.
- Provide services in the same manner for all patients.
- Provide Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)/well-child visits for members through the month of their 21st birthday.
- Give you regular immunizations as needed.
- Keep track of your preventive health needs.
- Discuss what advance directives are and file the directive appropriately in your medical record.
- Make sure you receive hospital services if medically necessary.

Choosing Your Primary Care Provider (PCP)

As an Absolute Total Care member, you may choose your PCP. You can also choose a PCP for your child. Multiple members of a family enrolled with Absolute Total Care may all choose the same PCP or each member may choose a different PCP. A list of PCPs can be found in the mobile app, the Secure Member Portal and on our website at absolutetotalcare.com. If you need help finding a PCP, call Member Services at 1-866-433-6041 (TTY: 711).

Your PCP may be one of the following:

- Family practitioner
- General practitioner
- Internal medicine
- Pediatrician

It is important to call your PCP first when you need care. Your PCP will manage your healthcare needs. Your PCP works with you to get to know your health history and helps take care of your health.

You should always call your PCP's office when you have a question about your healthcare. He or she can help you get other services you may need. Your PCP must provide coverage 24 hours a day, seven days a week. It is best to call your PCP during normal business hours. If your PCP's office is closed, you may call your PCP's after-hours telephone number that may connect you to an answering service, a nurse on call, your PCP, or another provider authorized by your PCP.

Women may have an OB/GYN doctor or a certified nurse midwife in addition to their PCP during their pregnancy. Female members may also receive routine and preventive healthcare from a women's health specialist outside of pregnancy.

Indian members may choose a participating Indian Health Care Provider (IHCP) PCP as their PCP if the provider has the capacity to provide services.

Absolute Total Care has PCPs who are sensitive to the needs of many cultures, speak your language, and understand your family traditions and customs. If you want more information about your PCP's qualifications, please call Member Services at 1-866-433-6041 (TTY: 711).

Primary Care Provider (PCP) Assignment

Absolute Total Care assists members who have not chosen a PCP upon enrollment with the health plan.

The member's new PCP is selected based on one of the following reasons:

1. If the member has used the doctor in the past.
2. The ZIP code in which the member resides.

Continuity and Coordination of Care

Absolute Total Care lets you know if your PCP or your PCP's office is no longer in Absolute Total Care's network. We send you a letter at least 60 calendar days prior to the effective date of the PCP's termination. If the PCP notifies Absolute Total Care of termination less than 30 calendar days prior to the effective date, Absolute Total Care notifies impacted members as soon as possible, but no later than 15 calendar days after the receipt of the notification.

We will help you change your PCP. We also let you know if a specialist you see regularly leaves our network. We will help you find another specialist.

Absolute Total Care honors Medicaid services that have been approved prior to joining our health plan. We refer you to SCDHHS for services outside Absolute Total Care's benefits.

Changing Your Primary Care Provider (PCP)

When you joined Absolute Total Care, you may have selected a PCP. If you did not, we assigned you a PCP.

To change your PCP, do one of the following:

- Call Member Services at 1-866-433-6041 (TTY: 711).
- Make a PCP Change Request in the mobile app or in the Secure Member Portal found on our website, absolutetotalcare.com.

You may change your PCP at any time if:

- Your PCP is no longer in your area.
- You are not satisfied with your PCP's services.
- The PCP does not provide the services you seek because of religious or moral reasons.
- You want the same PCP as other family members.

Scheduling/Appointment Waiting Times

Primary Care Provider (PCP) Appointment Access Standards	
Appointment Type	**Access Standard**
Routine visits for established patients	Within 15 business days
Urgent, non-emergency visits	Within 48 hours
Emergent or emergency visits	Immediately upon presentation at a service delivery site
24 Hour Coverage	24 hours a day, seven days a week by direct access or through arrangement with a triage system
Office wait time for scheduled routine appointments	Not to exceed 45 minutes
Walk-in appointments/non-urgent	Should be seen if possible or scheduled for an appointment
Specialty Care Provider Appointment Access Standards *(OB-GYNs, Oncologists, Retail Pharmacy, Autism Services)*	
Appointment Type	**Access Standard**
Routine visits for established patients	Within 15 business days
Urgent, non-emergency visits	Within 48 hours
Emergent or emergency visits	Immediately upon presentation at a service delivery site

24 Hour Coverage	24 hours a day, seven days a week by direct access or through arrangement with a triage system
Office wait time for scheduled routine appointments	Not to exceed 45 minutes
Walk-in appointments/non-urgent	Should be seen if possible or scheduled for an appointment
Behavioral Health Provider Appointment Access Standards	
Appointment Type	**Access Standard**
Initial visit for routine care	Within 10 business days
Follow-up routine care for established patients	Within 15 business days
Care for a non-life-threatening emergency	Within 6 hours or referred to the emergency room or behavioral health crisis unit
Urgent, non-emergency visits	Within 48 hours
Emergent or emergency visits	Immediately upon presentation at a service delivery site
24 Hour Coverage	24 hours a day, seven days a week or triage system approved by Absolute Total Care
Office wait time for scheduled routine appointments	Not to exceed 45 minutes
Walk-in appointments/non-urgent	Should be seen if possible or scheduled for an appointment
Other Required Specialty Care Provider Appointment Access Standards	
Appointment Type	**Access Standard**
Routine visits for non-symptomatic care	Within four and a maximum of twelve weeks for unique specialists
Urgent medical condition visits	Within 48 hours of referral or notification of the PCP
Emergent or emergency visits	Immediately upon referral
Indian Member Referrals	Allow for Indian Health Care provider referrals of an Indian member

If you have trouble getting an appointment, call Member Services at 1-866-433-6041 (TTY: 711). Remember to bring your Absolute Total Care member ID card and Medicaid ID card with you to your appointments. Please be on time so that you can be seen as scheduled. Do your best to avoid being a “no show” for your scheduled doctor appointments. If you need to cancel or reschedule your appointment, call your doctor as soon as you can, use an online patient portal, or reply to an automated reminder.

BENEFIT INFORMATION

Copayments/Cost-Sharing

Absolute Total Care does not require copayments or cost-sharing for any service.

Services Covered and Not Covered by Absolute Total Care

Absolute Total Care wants you to stay healthy. Many health problems can be avoided if they are found early enough. The information in this section summarizes the covered services available to you under this plan. Absolute Total Care covers all medically necessary Medicaid covered services.

If you have questions about these services, call us. We can be reached at 1-866-433-6041 (TTY: 711). A Member Services representative will help you understand your benefits.

Benefits	Coverage	Limits	Authorization Requirements
Abortion Procedure	Covered	Covered according to applicable federal and state laws and regulations. Written physician certification of the need for the abortion required.	Prior approval required.
Acne	Covered	Ages 18 and younger. Limits apply.	
Acupuncture and Biofeedback Service	Not Covered		
Ambulance Services– Emergency and Non-Emergency	Covered		
Ambulatory Surgical Center	Covered	Copay is applied per day.	Prior approval may be required for some services.
Autism Spectrum Disorder (ASD) Treatment Services	Covered	Ages 21 and younger.	Prior approval may be required for some services.
Audiology Services	Covered	Ages 20 and younger.	
BabyNet	Covered	Ages 3 and younger.	

Bariatric Surgery – Surgery for Morbid Obesity	Covered		Prior approval required.
Behavioral Health - Evaluation (Outpatient)	Covered	One evaluation every six months.	
Behavioral Health – Medical Office Visit (Psychiatrist or Nurse Practitioner Only)	Covered	Psychiatrist or nurse practitioner only.	
Birthing Centers	Covered		Prior approval required.
Biopharmaceuticals (Specialty Injectables)	Covered		Prior approval required.
Cardiac Rehabilitation Services	Covered		Prior approval may be required for some services.
Chemotherapy Services	Covered		Prior approval may be required for some services.
Chiropractic Services	Covered	One per day/six per year	
Circumcision	Covered	Covered during the initial newborn stay and up to 180 days after delivery in the office setting. Otherwise, prior approval required.	Prior approval may be required.
Clinic Visits	Covered		
Cosmetic Surgery	Not Covered		
Dermatology Services	Covered	Cosmetic is not covered.	Prior approval may be required for some services.
Developmental Evaluation Services	Covered	Covered for members between the ages of 0 and 21.	
Diabetic Shoes	Covered	One pair per year (three inserts per year).	
Diabetic Supplies (Test Strips, Lancets, Pen Needles)	Covered	Quantity limits may apply.	Prior approval may be required.
Diabetic Education	Covered		
Dialysis	Covered		Prior approval required.

Durable Medical Equipment (DME) – Including, but not limited to, Rental Equipment, Supplies, Wheelchairs, Ventilators, Oxygen, Monitors, Lifts, Nebulizers, and Bili-Blankets.	Covered		Prior approval may be required for some equipment.
Emergency Care (In-Network and Out-of-Network)	Covered		
Emergency Transportation	Covered		
Enteral/Parenteral Nutrition Therapy	Covered	If provided via tube and sole source of nutrition.	
Family Planning Services	Covered	Self-referrals: in- and out-of-network providers covered.	
Fluoride Rinse/Varnish	Covered	As a part of EPSDT only.	
Genetic Testing	Covered		Prior approval required.
Hearing Tests, Aids, and Devices	Covered	Ages 20 and younger.	Prior approval required.
Home Health Care	Covered	50 visits per year (July 1 through June 30).	Prior approval required.
Home Infusion Therapy	Covered		Prior approval may be required for some medications.

Hysterectomy	Covered	Completed Consent for Sterilization Form (Form HHS-687) required.	Prior approval required.
Infertility Services	Not Covered	N/A	
Infusion Centers	Covered		
Inpatient Behavioral Health Services	Covered		Prior approval required.
Inpatient Medical/Surgical Services	Covered		Prior approval required.
Inpatient Pediatric Rehabilitation Services	Covered		Prior approval required.
Insulin Pumps	Covered		Prior approval required.
Laboratory Services	Covered		Prior approval required for some services.
Maternity Services	Covered		Prior approval required for some services.
Newborn Hearing Screening	Covered	Included in the Core Benefits when provided to newborns in an inpatient hospital.	
Non-Participating Providers	Covered	Must be medically necessary and service not available in network.	Prior approval required.
OB Ultrasounds	Covered	Maternal-fetal medicine provider: no limitation. All other providers: three ultrasounds per pregnancy.	
Office Visits (PCP/Specialists) (Well and Sick Visits)	Covered		

Oncology-Related Chemotherapeutic Drugs and Support Services	Covered		Prior approval required.
Orthopedic and Spinal Surgery	Covered		Prior approval required.
Orthotics and Prosthetics	Covered	Braces (non-dental) and other mechanical or molded devices to support or correct any defect of form or function of the human body.	Prior approval required for some services.
Outpatient Hospital Services (Non-Emergency)	Covered		Prior approval required for some services.
Outpatient Surgery and Procedures	Covered		Prior approval required for some services.
Pain Management Services	Covered		Prior approval required for some services.
Podiatry Services	Covered		Prior approval required for some services.
Power Wheelchairs	Covered	Every seven years, limited accessories covered.	Prior approval required.
Prescriptions and Medications	Covered	Subject to age and quantity limits per Comprehensive Drug List (CDL).	Prior approval may be required for some medications.
Pulmonary Rehabilitation Services	Covered		
Rehabilitative Therapies for Children, Non-Hospital Based	Covered	Ages 20 and younger, combined total of 105 hours (420 units) per year (July 1 through June 30).	Prior approval required.
Reversal of Sterilization	Not Covered		

Smoking Cessation Products	Covered	Subject to quantity limits per Comprehensive Drug List (CDL).	
Sterilization	Covered	Completed Consent for Sterilization Form (Form HHS-687) required.	
Substance Use Disorder Services	Covered		Prior approval required for some services.
Transplants	Covered		Prior approval required.
Vaccines/Immunizations (Adult)	Covered	Covered in accordance with the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) vaccine recommendations guidelines for adult beneficiaries 19 years of age and older.	

Vaccines/Immunizations (Children)	Covered	Covered by the Vaccine for Children's (VFC) Program. Ages 18 and younger.	
Vision – Routine Screening (Children)	Covered	Ages 20 and younger. One pair of glasses every 12 months. One replacement set every 12 months.	
X-Ray/Radiology and Imaging Services	Covered		Prior approval required for some services.

Behavioral Health

"Behavioral health" is a phrase we use to talk about mental health, alcohol, drug, and substance abuse. Absolute Total Care offers a number of behavioral health programs and services to our members. You can choose any behavioral health provider in our network. You don't need a referral from your PCP. We also cover services offered through the Office of Substance Use Services (OSUS). You can contact Absolute Total Care at 1-866-433-6041 (TTY: 711).

Absolute Total Care manages behavioral healthcare through comprehensive individualized care plans. We support our members with services such as peer and family support that help keep them in their communities. Our Care Managers work directly with members to help them overcome any barriers to achieving their goals.

Absolute Total Care manages inpatient and outpatient behavioral health services for members as they transition from one level of care to another through the coordination of services such as:

- Peer and family support
- Assessments
- Individualized care plan development and modification
- Therapy services
- Alcohol, drug, and substance abuse
- Arranging appointments

Absolute Total Care also manages Rehabilitative Behavioral Health Services (RBHS), Psychiatric Residential Treatment Services (PRTF), and Autism Spectrum Disorder (ASD) services. Services are provided for the purpose of reducing the effects of mental health difficulties or substance use and improving the ability to function independently. Treatment to assist in restoring maximum function is provided through a variety of diagnostic and restorative services such as:

- Screenings and assessments
- Psychological evaluation and testing
- Psychotherapy
- Service plan development
- Crisis management
- Medication management
- Psychosocial rehabilitation
- Behavior modification
- Family support
- Community integration
- Peer support
- Substance abuse treatment

OSUS works with members to provide services to ensure the provision of quality services to prevent or reduce the negative consequences of alcohol, drug, and substance use addictions.

There are three basic types of OSUS services that are available through the statewide service-delivery system:

- Prevention
- Intervention
- Treatment

Second Opinions

You have the right to a second opinion. You can see another Absolute Total Care provider. You can also see a provider that is not with Absolute Total Care if an Absolute Total Care provider is not available in-network and if medically necessary. You will need an authorization if the provider is not in Absolute Total Care's network. There is no cost to you. Call Member Services at 1-866-433-6041 (TTY: 711) for assistance getting a second opinion.

Transplant Services

Absolute Total Care covers all medically necessary organ transplant care including specialist doctor appointments, testing, and other pre-transplant care, your hospital stay for the transplant procedure itself, and the care you need after the transplant including doctor visits, testing, and medications. Absolute Total Care will work with your doctor to get prior authorization.

All members that are identified as needing a transplant will be contacted by one of Absolute Total Care's transplant care managers. Our transplant care managers are specially trained nurses with transplant care experience who will help and assist you throughout the entire process. We highly recommend communicating with them so they can help make sure you receive all the medically necessary services before and after the transplant, including making sure you have access to and receive any special medications your doctor prescribes you. They also help you identify and overcome any barriers you may have receiving needed care, help and address any special post-transplant needs, and coordinate care and services whether you receive care in South Carolina or especially out-of-state. For more information, you or your doctor can contact our Central Transplant Unit (CTU) at 1-866-447-8773.

Durable Medical Equipment (DME)

DME is equipment your doctor orders that has exclusive medical use. These items must be reusable and may include wheelchairs, hospital-type beds, crutches, walkers, splints, and respirators. To qualify for benefits, your physician must order the medical equipment, and it must be medically necessary to meet a specific need.

Equipment such as air conditioners, whirlpool baths, spas, (de)humidifiers, wigs, fitness supplies, vacuum cleaners, or air filters do not qualify because they do not have exclusive medical uses. To be eligible as DME, the device or equipment's use must be limited to the patient for whom it was ordered. This means others cannot use the device or equipment.

Absolute Total Care follows SCDHHS DME rental guidelines. Prior approval may be required for some DME.

- Capped rental equipment cannot initially be purchased. A capped rental item is only considered purchased when it has been rented for a maximum of 10 months. Some examples of capped rental equipment include manual hospital beds with mattress side rails, respiratory assist devices, insulin pumps, and standard manual wheelchairs.
- Most parenteral infusion pumps are capped rental items except for nutrition infusion pumps with or without alarm, stationary and portable parenteral nutrition infusion pumps, ambulatory infusion pumps, and stationary parenteral infusion pumps. These items are not considered purchased after the tenth month of rental and can continue to be rented.
- Limited rental equipment has a limited rental period and cannot be rented over 10 months. Some examples of limited rental equipment include powered air overlay mattresses, power pressure-reducing air mattresses, and negative pressure wound therapy electrical pumps.
- Maintenance of rented equipment is not covered by Absolute Total Care. Parts and supplies used in the maintenance of rented equipment are included in the rental payment of the equipment.

Out-of-Network Services and Doctors

Absolute Total Care realizes that there may be times when you need care from a doctor who is not in Absolute Total Care's provider network. These services can be arranged if medically necessary. Please contact your Absolute Total Care network PCP to discuss these needs.

Absolute Total Care will approve medical services from an out-of-network provider if these services are not available in-network and are medically necessary, as determined by your PCP and Absolute Total Care. Indian members may obtain covered services from out-of-network Indian Health Care Providers (IHCPs) from whom the member is otherwise eligible to receive such services.

Member Billing

You will only be billed by a provider if:

- You signed a Member Acknowledgement Statement, which makes you responsible for services not covered by Absolute Total Care.
- You agreed ahead of time to pay for services that are not covered by Absolute Total Care or Medicaid Fee-for-Service.
- You agreed ahead of time to pay for services from a provider who is not in the network and/or did not receive a prior authorization ahead of time and requested the services anyways.

If You Are Billed

If you have Medicaid, you should not be billed for any service covered by Medicaid.

If you get a bill for services Absolute Total Care should have paid, call Member Services at 1-866-433-6041 (TTY: 711). When you call, give the Member Services staff:

- Date of service
- Name of provider
- Total amount of the bill

State-Covered Services

Absolute Total Care does not cover all your services. Some services are covered by Medicaid Fee-for-Service and are called "carved-out benefits." Call us with any questions you have about these services. You can also contact SCDHHS toll-free at 1-888-549-0820.

State covered services include:

- Community Long-Term Care Waiver Services
- Routine and Emergency Dental Services (DentaQuest)
    - Phone: 1-888-307-6553
- HIV/AIDS Waiver Services
- Hospice Care
- Long-Term Institutional Care
- Mechanical Ventilator Dependent (VENT) Waiver Services
- Non-Emergency Medical Transportation (ModivCare)
- Targeted Case Management (TCM)

Community Long Term Care Waiver Services

In-home or community-based support services that assist persons with long-term care needs to remain at home. The Community Choices (CC) waiver for Medicaid-eligible participants who are aged eighteen (18) or older, have long term care needs, and meet nursing home level of care. To avoid or delay costly nursing home admission, participants can access the services necessary to receive care at home through careful assessment, service planning, care coordination and monitoring.

Dental Services

Routine and emergency dental services are available to those Members under the age of twenty-one (21). Limited dental services are available to those Members aged twenty-one (21) and over. The dental Program for all Members is administered by SCDHHS's dental broker, DentaQuest. The DentaQuest tollfree number is 1-888-307-6553.

HIV/AIDS Waiver Services

The Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) waiver is for Medicaid-eligible participants with HIV/AIDS, regardless of age, who choose to live at home but have long term care needs and are at risk for hospitalization.

Hospice Services

Services in which the Member is provided palliative care (relief of pain and uncomfortable symptoms) as opposed to curative care for terminally ill individuals.

Long-Term Institutional Care

Institutional long-term care services in a long-term care facility are covered upon approval by CLTC and reimbursed by Medicaid Fee-For Service.

Mechanical Ventilator Dependent (VENT) Waiver Services

The Mechanical Ventilator Dependent (Vent) waiver is designed to serve Medicaid-eligible participants aged 21 or older who are dependent on mechanical ventilation at least six (6) hours per day and have long term care needs. Participants can receive services to supplement care in their home to avoid or delay costly nursing home admission, through careful assessment, service planning and service coordination.

Transportation

South Carolina's Medicaid Transportation program provides non-emergency transportation for members. If you need to schedule a ride for a non-emergency reason, please call the Modivcare reservation line for the region that your county is located in.

Region 1: Abbeville, Anderson, Cherokee, Edgefield, Greenville, Greenwood, Laurens, McCormick, Oconee, Pickens, Saluda, Spartanburg
Reservations: 1-866-910-7688
Late or Missing Ride: 1-866-910-7689
Administrative Line: 1-866-910-7684

Region 2: Aiken, Allendale, Bamberg, Barnwell, Calhoun, Chester, Clarendon, Fairfield, Kershaw, Lancaster, Lee, Lexington, Newberry, Orangeburg, Richland, Sumter, Union, York
Reservations: 1-866-445-6860
Late or Missing Ride: 1-866-445-9962
Administrative Line: 1-866-910-7684

Region 3: Beaufort, Berkeley, Charleston, Chesterfield, Colleton, Darlington, Dillon, Dorchester, Florence, Georgetown, Hampton, Horry, Jasper, Marlboro, Marion, Williamsburg
Reservations: 1-866-445-9954

Late or Missing Ride: 1-866-445-9964
Administrative Line: 1-866-910-7684

Statewide number for nursing homes and medical facilities: 1-866-420-6231

Call Member Services at 1-866-433-6041 (TTY: 711) if you are having a problem scheduling a ride to your medical appointment. Member Services will assist you in contacting your transportation broker to arrange transportation.

Targeted Case Management (TCM)

Services that assist individuals with specialized needs gain access to needed medical, social, educational, and other services to include a systematic referral process to the service with documented follow-up. TCM services are available to alcohol and substance abuse individuals, children in foster care, mentally ill adults, emotionally disturbed children, children in the juvenile justice system, sensory impaired individuals, individuals with intellectual disabilities or a related disability, individuals with head or spinal cord injury or a related disability, children and adults with sickle cell disease and adults in need of protective services. Patients who are dually diagnosed with complex social and medical problems may require TCM services from more than one Case Management Provider. Absolute Total Care will assist with referrals and coordinating health care for members that require TCM services that avoid duplication and ensure that the members' needs are adequately met.

Quality Improvement (QI)

Absolute Total Care is committed to providing quality healthcare to you. Our primary goal is to improve your health and help you with any illness or disability. Our QI Program is consistent with National Committee for Quality Assurance (NCQA) and Institute of Medicine (IOM) priorities. To help promote safe, reliable, and quality healthcare, our programs include:

- Conducting a thorough check on providers when they become part of Absolute Total Care's provider network
- Monitoring the access Absolute Total Care members have to all types of healthcare services
- Providing programs and educational items about general healthcare and specific diseases
- Sending reminders to you to get annual tests, such as adult physical, cervical cancer screening, and breast cancer screening
- Investigating your concerns regarding the healthcare you have received. If you have a concern about the care you received from your PCP or any service provided by Absolute Total Care, please contact Member Services at 1-866-433-6041 (TTY: 711)

Absolute Total Care believes that getting input from members, like you, can help make the services and quality of our programs better. We conduct a member survey each year that asks questions about your experience with the healthcare and services you are receiving. If you receive one of our member surveys, please be sure to fill out the survey and drop it back in the mail.

Utilization Management

Utilization Management is a part of Absolute Total Care that makes decisions about your recommended healthcare benefits. The Utilization Management staff checks to see if a service is covered and makes sure it is medically necessary. They also make sure it will be at the right place and at the right time. Utilization Management approves services when they are medically necessary. Decisions are based on nationally recommended appropriate care. No financial incentives are used to deny care. The Utilization Management staff also conducts hospital reviews and coordinates with the hospital discharge planner to facilitate your plan of care.

Medically Necessary Services

Services that are medically necessary are those that:

- Prevent illness and conditions.
- Treat pain and body problems.
- Agree with medical standards.
- Are provided in a safe place for the service.

Prior Authorization

Prior authorization means your provider must get approval from Absolute Total Care before you can get the service, procedure, or equipment.

How It Works

Your provider submits the prior authorization request to Absolute Total Care. Absolute Total Care reviews the request before you obtain the service, procedure, or equipment. We check to see if the service, procedure, or equipment is covered and if they are medically necessary. Absolute Total Care has policies and procedures to follow when they make decisions regarding medical services. Decisions are based on appropriate care, and no financial reasons are used to deny care.

Standard (Non-Urgent) Prior Authorization Requests

Prior authorization requests for standard, or non-urgent services, are reviewed and notification of a decision is made within **7 calendar days** from the time the request was received.

An extension for an additional **14 calendar days** may be granted if you, your provider or your authorized representative requests an extension or if Absolute Total Care can show the need for additional information and the extension is in your best interest.

Expedited (Urgent) Prior Authorization Requests

Expedited, or urgent, prior authorization requests are made when a provider, or Absolute Total Care, determines that following the non-urgent request time frame could seriously jeopardize your life, health, or ability to attain, maintain, or regain maximum function. Expedited prior

authorization requests are reviewed and notification of a decision is made within **72 hours** from the time Absolute Total Care receives the request through 12/31/2026, and within **48 hours** of receiving the request on and after 1/1/2027.

An extension may be made up to **14 calendar days** if you or your authorized representative requests an extension or if, within **24 hours** of receiving the request, Absolute Total Care justifies a need for additional information and the extension is in your best interest.

Note: Except for emergency services and family planning, all services must be obtained through Absolute Total Care network providers or prior approved out-of-network providers. If your doctor is outside the network, or an in-network doctor is not available, you need a prior authorization. We can help you get the services you need at no charge to you. Call Member Services at 1-866-433-6041 (TTY: 711).

Pharmacy

You may call Member Services or visit our website to see drugs that are on the Absolute Total Care approved list of covered medications. This is called a comprehensive drug list (CDL). The CDL lets your doctor know what drugs Absolute Total Care covers and any restrictions that may apply. To view the CDL: https://www.absolutetotalcare.com/members/medicaid/benefits-services/pharmacy.html, select the "Which Drugs are Covered" tab then select the "Comprehensive Drug List" document. Absolute Total Care is required to align with the SCDHHS single, state-directed pharmacy benefit preferred drug list (PDL). SCDHHS single PDL can be found at https://www.scdhhs.gov/providers/pharmacy. Some over-the-counter (OTC) medicines are covered if your doctor writes you a prescription. If you need an OTC medicine that is not covered, you will have to pay for it. A list of pharmacies in your area can be found in the mobile app, the Secure Member Portal, on our website at absolutetotalcare.com or you may call Member Services at 1-866-433-6041 (TTY: 711). A Member Service representative will help you find a pharmacy.

How do you get your prescriptions?

- Go to a pharmacy that is signed up with Absolute Total Care.
- Give them your prescription order.
- Show them your Absolute Total Care member ID card.

Absolute Care does not require a copay for any service. You will pay $0 for each prescription.

There is a 31-day supply limit per prescription filled, new or refilled. Select preferred drugs used to treat conditions such as, but not limited to, diabetes, hypertension and high cholesterol may be eligible for up to a maximum of 90 days' supply. Please contact Absolute Total Care at 1-866-433-6041 (TTY: 711) if you have questions about copayments or days' supply limits.

What is Prior Authorization?
Prior authorization means your provider must get approval from Absolute Total Care before you can get the medication. Your medication may need a prior authorization if it is not on the CDL or does not follow the CDL requirements/limits.

Absolute Total Care providers have been notified in writing of:

- The drugs included in the CDL.
- How to request a prior authorization.
- Special procedures set up for urgent requests.

Prior Authorization
Prior authorization requests will be reviewed, and notification of a decision is made within **24 hours** from the time a complete request was received.

How It Works
Your provider requests a prior authorization if your medication is non-preferred, is not on Absolute Total Care's CDL or does not follow the CDL limits. You may be eligible for a 72-hour emergency supply until your provider can submit a request, and a decision is made by Absolute Total Care.

Absolute Total Care reviews the request before you obtain the medication. We will check to see if the medicine is covered and if it is medically necessary. Absolute Total Care has policies and procedures to follow when they make decisions regarding medications. Decisions are based on appropriate care, and no financial reasons are used to deny care.

If Absolute Total Care does not approve the request, we will notify you and your doctor. We give you information about the grievance and appeal process and your right to a State Fair Hearing. If you or your provider do not agree with our decision, please let us know.

Step Therapy
Sometimes Absolute Total Care requires you to do step therapy. This means you will have to try medicines in the CDL in a certain order before we cover another medicine. If Absolute Total Care does not have record that the step through medicine(s) have been tried, then a prior authorization will be required. If Absolute Total Care does not approve the prior authorization request, we will give you information about the grievance and appeal process and your right to a State Fair Hearing. If you or your provider do not agree with our decision, please let us know.

For the most current CDL, you can call Member Services at 1-866-433-6041 (TTY: 711) or you can find a link on our website at absolutetotalcare.com under the "Which Drugs are Covered" section.

BabyNet

BabyNet services are for children from birth to age three (3) with developmental delays, or conditions associated with developmental delays, meeting SCDHHS BabyNet eligibility criteria. Call Absolute Total Care at 1-866-433-6041 (TTY: 711) for more information, including eligibility requirements.

Developmental Evaluation Services

Developmental Evaluation Services are medically necessary services for members between the ages of 0 through the month of their 21st birthday that have or are suspected of having a developmental delay, behavioral or learning disability or other disabling condition. These services are for facilitating correction or improvement of physical, emotional and/or mental illnesses and other conditions, which if not treated, would negatively impact the health and quality of life of the member.

Rehabilitative Therapy for Members Ages 20 and Younger

Absolute Total Care provides rehabilitative services to members aged 20 and under who have issues with sight or hearing, physical disabilities, and/or intellectual/developmental disabilities or delays. These services include:

- Speech-language pathology
- Physical therapy
- Occupational therapy
- Audiological Services

Medically necessary services will need an authorization to cover up to 105 hours per year (July 1 through June 30). If you think your child is in need of these services, get a referral from their PCP for an evaluation.

EXTRA BENEFITS

Additional Services

Absolute Total Care provides additional services for Absolute Total Care members that provide additional benefits beyond the SCDHHS covered services. The additional services below exceed SCDHHS benefits and are designed to improve members' well-being, encourage responsible and prudent use of healthcare benefits, and enhance the cost effectiveness of the South Carolina Medicaid Program. Some Members may not qualify for some of the additional services listed.

Need help understanding these benefits and services? Call us at 1-866-433-6041 (TTY: 711). We can help! You can also view more information on-line at AbsoluteTotalCare.com

Breast Pump: New moms can receive an electric breast pump at no cost. Members are eligible to request the breast pump 12 weeks before delivery and up to 30 days after delivery (within 90 days for NICU babies). Call 877-394-1860 for more information or complete the Breast Pump Member Request Form. Limit one per calendar year.

Cell Phone Program: The SafeLink program provides free talk, text and data for qualifying Absolute Total Care members. This program provides communication with members' primary care provider, Care Manager, certain family members instrumental in their care, and our 24/7 nurse advice line. Enroll in the program today by visiting the SafeLink website.

General Education Diploma (GED) Testing: Provides vouchers for members over 16 to take the GED Exam at no cost.

Housing Assistance: Absolute Total Care assists qualifying members in locating temporary or permanent housing accommodations, accessing community resources and will deliver a Welcome Kit on or near the member's move-in day at no cost.

90-Day Medication Supply: Receive a 90-day supply of medicines to help control high blood pressure, diabetes and high cholesterol for select medications. View our 90-Day Supply Medication List available online under Benefits Overview on the website to see the list of eligible medications.

Over-the-Counter (OTC) Benefit: Members receive $15 quarterly allowance per household, up to $60 annually, of OTC products per household. No prescription is required, and items are mailed to your home. Unused funds at the end of each quarter do not carry over.

Ordering is easy! And you can choose from hundreds of items, including children's health products, first aid supplies, pain relievers and more. For a full list of eligible OTC items, view our OTC Benefit Brochure available online under Benefits Overview.

Members can place an order by the following methods:

- Order online on the CVS website.
- Call CVS at 1-888-628-2770 (TTY: 711) Monday to Friday, from 9 am to 8 pm.
- Shop at any OTC Health Solutions® (OTCHS) enabled CVS store. To find the closest participating location, visit the CVS website.

Postpartum Meals: Qualifying birth parents who have a delivery on record qualify for 14 free, home-delivered postpartum meals.

Reading Skills Development Program: Provides books and tutoring sessions to qualified members (Pre-K - fifth grade) to improve reading skills at no cost.

Safe Sleep Kit: Provides safe sleep kit for high-risk members who are engaged in Case Management at no cost.

Smoking Cessation: Provides smoking cessation counseling and medications at no cost.

Sports Activity Fee: Absolute Total Care covers the sports activity fee for members 5-18 years old. Members can receive up to $50 annually through the My Health Pays rewards program.

This benefit covers the program activity/registration fee only.

Sports Physical: Absolute Total Care covers one sports physical with a qualified provider per year for members 5-18 years old.

Start Smart for Your Baby Educational Program: Provides pregnancy and postpartum educational information to qualifying members at no cost.

Substance Use Disorder Program: Provides substance use disorder program for at-risk members at no cost.

Suicide Prevention Program: Provides suicide prevention program for at-risk members at no cost.

Start Smart for Your Baby® (Start Smart)

Start Smart is an Absolute Total Care program for pregnant persons and birth parents who have just had a baby. Start Smart gives you information about how to take good care of yourself and your baby. It also helps you with problems that come up while you are pregnant. We know having a baby can be hard on you and your family. We want to help. Educational information is given by mail, telephone, and through our website, www.startsmartforyourbaby.com.

We care about the health of both you and your baby. You should go to your doctor as soon as you think you are pregnant. It is important to take your baby to the doctor. Your baby needs regular shots and health screenings.

We have many ways to help you have a healthy pregnancy. Before we can help, we need to know you are pregnant. Please call us at 1-866-433-6041 (TTY: 711) as soon as you learn you are pregnant. We set up the special care you and your baby need.

My Health Pays™ Rewards

Earning My Health Pays™ Reward Dollars

After you complete a healthy activity, Absolute Total Care adds the reward dollars you have earned directly to your My Health Pays™ Visa® Prepaid Card.

Starting January 1, 2027, all members must sign up for the My Health Pays™ rewards program before earning rewards. Even if you already have a card, you must sign up to keep earning rewards.

Sign up for the program at absolutetotalcare.com after January 1, 2027. You only need to sign up once.

We mail your My Health Pays™ Visa Prepaid Card to you after you complete your first healthy activity. You can keep earning My Health Pays™ rewards by completing more healthy activities. Your rewards are added to your card once we are notified.

How to Earn

You can earn My Health Pays™ rewards for things like screenings, preventive care, and more. Visit absolutetotalcare.com for more details.

Use Your My Health Pays™ rewards to help pay for:

- Everyday items at Walmart**
- Utilities
- Transportation
- Telecommunications
- Childcare services
- Education
- Rent

For more information about Absolute Total Care's Member Rewards Program, visit our Rewards Program webpage. You can also log in to the Secure Member Portal to see your My Health Pays™ rewards balance.

**Earn up to $150 in rewards each calendar year.*

***This card may not be used to buy alcohol, tobacco, or firearms products.*

This card is issued by The Bancorp Bank pursuant to a license from Visa U.S.A Inc. The Bancorp Bank; Member FDIC. Card cannot be used everywhere Visa debit cards are accepted. See Cardholder Agreement for complete usage restrictions.

Funds expire 90 days after termination of insurance coverage or 365 days after date reward was earned, whichever comes first.

PROGRAMS

Preventive Guidelines

Preventive guidelines are based on the health needs and opportunities for improving you and your child's health. These guidelines help you develop a personal treatment plan with your PCP and your child's PCP. To see these guidelines, go to absolutetotalcare.com or call Member Services at 1-866-433-6041 (TTY: 711) and we can send you more information.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)/Well-Child Visits

EPSDT is a preventive healthcare program for South Carolina Medicaid members. The EPSDT program helps find and treat children's health problems early. Absolute Total Care offers this program to children, teens, and young adults through the month of their 21st birthday.

Checkups are important for your child's health. These checkups for children are called EPSDT visits or well-child visits. Well-child visits cover complete health checkups, including a health and developmental history at no cost to you. Your child may look and feel well but still have a health problem. Well-child visits can help tell if your child may have any medical, mental, eye, or dental problems.

Children with their first tooth eruption and ages two and older are referred to a dentist. Routine dental services are provided by Medicaid Fee-for-Service. Call 1-888-307-6552 to find a dental provider in your area.

Ask your child's PCP when your child should have their next well-child visit exam. Children need more health checkups than adults do. Your doctor wants to see your child for regular checkups, not just when they are sick.

Call Absolute Total Care at 1-866-433-6041 (TTY: 711) for more information. A representative will help you learn about exams, screenings, and shots.

During an EPSDT/well-child visit, your doctor performs a comprehensive unclothed exam including a complete health and developmental history, as well as providing health education and counseling. The visit also includes:

- Growth and size status
- Body mass index (BMI) percentile
- Appropriate immunizations
- Diet and nutrition review
- Developmental review assessment
- Anticipatory guidance
- Baby, child, and teen behavioral skills
- Mouth and teeth exam
- Blood pressure
- Ears and eyes screening
- Cervical dysplasia screening as recommended by the doctor
- Tuberculosis risk review and skin test
- Provide needed shots and reviewing shot records
- Review test records

- Lead risk assessment
- Blood collections such as anemia and lead screening

Your child should receive a blood lead test at age 12 months and at age 24 months.

At an EPSDT/well-child checkup, your child's doctor will:

- Check to make sure your child is growing well.
- Help you care for your child.
- Talk to you about the best food to give your child.
- Give you tips on how to help your child sleep.
- Answer questions you have about your child.
- See if your child has any problems that may need more healthcare.
- Give your child shots that will help protect him or her from illnesses/diseases.

When to Have an EPSDT/Well-Child Visit
The first checkup happens in the hospital right after your baby is born. EPSDT/well-child visits are recommended at the ages listed in the Infancy, Early Childhood, Late Childhood, and Adolescence section of this Member Handbook.

Infancy, Early Childhood, Late Childhood, and Adolescence

Infancy	Early Childhood	Late Childhood Adolescence
Birth 3-5 days 1 month 2 months 4 months 6 months 9 months	12 months 15 months 18 months 24 months 30 months 3 years 4 years	Ages 5 years and up through the month of the child's 21st birthday – every year

Care Management

If you have complex healthcare needs, behavioral health concerns, or need assistance finding help in areas such as housing, transportation, or other community resources, our Care Management Team may be able to help you.

Absolute Total Care's Case Management Team consists of individuals with specialties in several areas who can help you understand preventive health, wellness and major health problems, arrange care with providers, and help you obtain assistance in the community. A member of the

case management team will work with you and your provider to help you get the care you need. The care manager calls or schedules a home visit to assess your needs. You, your care manager, and PCP develop a personal care plan to work on your goals for your health and well-being. To contact the Case Management Program, please call 1-866-433-6041 (TTY: 711).

Foster Care

We have programs in place if you are caring for a child in foster care. Our program aims to identify health conditions that require prompt medical attention, assist with care coordination, including: acute illness, chronic conditions, therapy, nutritional and dental programs, and identifying signs of abuse or neglect. We communicate with foster parents and case workers to ensure children and their caregivers have access to the best in-network providers for care. We assign a care manager/care coordinator to help you navigate health.

Asthma

We have an Asthma Disease Management program for people with asthma. It will help you manage your asthma. Asthma is a disease that makes it hard to breathe. People with asthma:

- Are often short of breath.
- Have tightness in their chest.
- Make a whistling sound when they breathe.
- Cough a lot, morning and night.

While asthma cannot be cured, it can be controlled. If you or your children have asthma, our program helps you:

- Identify things that cause an asthma attack.
- Know when an asthma attack is occurring soon enough to prevent serious complications.
- Get the right medicine and devices to prevent an attack.
- See a doctor for treatment.

For more information, please call our Care Management Program at 1-866-433-6041 (TTY: 711). Be sure to call if you or your child:

- Has been in the hospital for asthma during the past year.
- Has been in the emergency room two or more times in the past six months for asthma.
- Has been in the doctor's office three or more times in the past six months for asthma.
- Takes medication for asthma.

Diabetes

Absolute Total Care has a special program for members with diabetes. A Diabetes Care Manager can answer your questions.

The Diabetes Care Manager works with you and your PCP to help keep your diabetes from controlling your life. If you have any questions about the program, please call 1-866-433-6041 (TTY: 711).

High-Risk Pregnancy

Absolute Total Care's Start Smart for your Baby® has a High-Risk Pregnancy Care Management program to provide guidance and assistance to our pregnant members who have complex pregnancy needs or other pregnancy-related complications.

We want you to see your doctor as soon as possible when you think you are having a baby. Getting early and ongoing prenatal care can help you have a healthy baby. Absolute Total Care has a High-Risk Pregnancy Care Management Team to help you get the services you need and coordinate those services if you have a high-risk pregnancy. When you see your doctor about your pregnancy, ask the doctor to send us your Notification of Pregnancy Form and if you need a referral to our High-Risk Pregnancy Care Management Program. Your doctor can arrange for our nurse to call and assist you in getting needed services and coordinating care for yourself and your infant.

You may contact our High-Risk Pregnancy Care Management Program directly by calling 1-866-433-6041 (TTY: 711).

New Technology

Absolute Total Care has a committee called the Centene Clinical Technology and Assessment Committee. This group consists of doctors. They review new treatments for people with certain illnesses. They review information from other doctors and agencies. The new treatments are shared with Absolute Total Care's providers. The doctors decide if the new treatment is the best treatment for our members. An example of new technology is the Cochlear Implant (covered benefit). This is a special hearing tool for people with a great deal of hearing loss.

Wellness and Disease Prevention

Absolute Total Care wants its members to lead a happy and healthy preventive lifestyle. Absolute Total Care's lifestyle management program and chronic conditions program provides health coaching, health assessment, and an incentive management guide to our healthy members to encourage healthy living. These programs include wellness, disease management, episodic/catastrophic care management, work-life resources and referrals, employee assistance, and professional training for populations of all types and sizes. Members may call 1-866-433-6041 (TTY: 711) for more information and to access Absolute Total Care's lifestyle management program.

ACCESSING CARE

Family Planning Services

This program provides counseling, diagnosis, treatment, birth control drugs, and supplies to help prevent unplanned and unintended pregnancy.

All family planning services are provided on a voluntary and confidential basis to all members, including those who are less than 18 years of age.

Covered services prescribed and furnished by physicians, hospitals, clinics, and pharmacies include:

- Examinations
- Assessments
- Diagnostic procedures
- Health education and counseling services related to alternative birth control and prevention
- Traditional contraceptive drugs and supplies
- Preventive contraceptive methods

Members are encouraged to receive family planning through their PCP or by appropriate referral to promote the integration of these services with their total plan of care. Members have the freedom to receive family planning services from any appropriate Medicaid provider without any restrictions and are free to choose the method of family planning to be used.

If the member receives these services from providers not contracted in Absolute Total Care's network, those providers are reimbursed by Absolute Total Care.

Women, Infants, and Children (WIC)

The WIC program helps women, infants, and children safeguard their health and well-being through nutrition. The program is run by the South Carolina Department of Public Health (SCDPH). Those who qualify receive vouchers to redeem for food items such as fruits and vegetables, dairy products, and cereal. For more information, please call SCDPH at 1-800-922-4406.

HIV Testing and Counseling

You can get HIV testing and counseling any time you receive family planning services. You do not need a referral from your PCP. Just make an appointment with a family planning provider. Absolute Total Care provides all necessary medical services. If you are at risk for hospitalization, you may be eligible for the AIDS Waiver Program operated by SCDHHS.

Outpatient Pediatric AIDS Clinic Services (OPACS) are available to children born to HIV-positive birth parents:

- If the baby does not test positive, the baby is covered for a visit once every three months until 2 years old.
- If the baby tests positive, the baby can be seen twice a week for eight weeks, then monthly until 2 years old.

Communicable Disease Services

You have the right to receive services from Absolute Total Care for any approved Medicaid enrolled provider for tuberculosis, sexually transmitted diseases, and HIV/AIDS services. You can also receive these same services from any state health agency.

Vaccines and Immunizations

Absolute Total Care wants its members to avoid disease at all costs. Vaccines and immunizations protect you and your children from serious diseases such as measles, whooping cough, and rubella. Recommended immunizations and vaccines for ages 18 and younger are covered by the Vaccines for Children (VFC) program. Immunizations are covered for adult members ages 19 and older in accordance with the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) vaccine recommendations guidelines. Covered services include the vaccine and administration of the vaccine. Adult vaccinations and immunizations include pneumococcal, influenza, recombinant zoster vaccine, Hepatitis A and B, Human Papillomaviris (HPV), measles, mumps, rubella and varicella (MMRV), rabies, serogroup B meningococcal (MenB); measles, mumps, and rubella (MMR); varicella (VAR); Tetanus and diphtheria toxoids (Td); Tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis vaccine (Tdap).

For more information and resources, contact Member Services at 1-866-433-6041 (TTY: 711).

Special Health Programs for Women

Absolute Total Care has special programs for women and girls. These programs can help you stay healthy and avoid problems.

Young Women and Girls

Young women and girls from ages 12 to 17 need extra care. This is because their bodies are changing. Young women and girls should get a well-child exam every year. This will help to make sure their body develops correctly. It will also help them deal with changes their bodies are going through.

Young women and girls should see their doctor every year. They should get to know their doctor well. Then their doctor will know them better, too. This will help young women and girls know how to get health services when they need them.

Healthy Women, Ages 18 to 45
Women ages 18 and older should see a doctor at least once a year to get any needed tests. These tests may include Pap tests, blood pressure, and lab tests. You can also get advice on a healthy diet and lifestyle.

Before You Become Pregnant

If you are thinking about having a baby, see your doctor right away. You need to get your body ready for pregnancy. Your doctor will want you to take special vitamins.

Family planning helps you have a healthy pregnancy and a healthy baby. For more information, call your PCP.

There are things you can do to have a safe pregnancy. See your doctor about any medical problems you have such as diabetes and high blood pressure. Do not use tobacco, alcohol, or street drugs now or while you are pregnant.

Some women have had problems with past pregnancies. These problems include:

- Three or more miscarriages
- Premature birth (when the baby arrives before 37 weeks of pregnancy)
- Stillborn baby

If any of these things have happened to you, see your doctor before you become pregnant. Your doctor will help you.

Take Folic Acid
Take folic acid every day. Start taking it even if you are not pregnant now. You should have plenty of folic acid in your body before you get pregnant and have plenty in your body during the first few months of pregnancy, too.

Foods that have folic acid in them include orange juice, green vegetables, beans, peas, fortified breakfast cereals, enriched rice, and whole wheat bread. It is very hard to get enough folic acid from food alone. Ask your doctor about taking vitamins.

See your doctor as soon as you think you are pregnant!

When You Are Pregnant

Keep these points in mind if you are pregnant now or want to become pregnant.

Get Care Right Away
Go to the doctor as soon as you think you are pregnant. It is important for you and your baby's

health to see a doctor as early as possible. Seeing your doctor early will help your baby get off to a good start. It is even better to see your doctor before you get pregnant to get your body ready for pregnancy.

Make an appointment with your dentist for a cleaning and checkup. Be sure to exercise and eat balanced, healthy meals. Rest for eight to 10 hours a night. Enjoy a healthier lifestyle.

Start Smart for Your Baby® (Start Smart)
Start Smart is our special program for birth parents who are pregnant. This program will help you take good care of yourself and your baby before the baby is born. Start Smart gives you information about being pregnant. It also helps you find solutions for any problems that might happen. We know having a baby can be hard on you and your family. We want to help.

We have many ways to help you have a healthy pregnancy. We need to know if you are pregnant. Please call us at 1-866-433-6041 (TTY: 711) as soon as you learn you are pregnant. We will set up the special care you and your baby need. We will send you some information that tells you how to have a healthy baby.

Smoking and Pregnancy
Smoking is bad for you whether you are pregnant or not. If you are pregnant, smoking adds more risks for your baby. If you smoke, you are more likely to have a miscarriage, have your baby too early, or have a stillborn baby. Smoking also puts your baby at risk for Sudden Infant Death Syndrome (SIDS).

Referrals

PCP referrals are not required for a member to see an Absolute Total Care network specialist. However, Absolute Total Care recommends that you always check with your PCP before going to see a specialist. Your PCP can recommend a specialist and assist in coordinating your care and request services before you get them.

Urgent Care/After Hours

Urgent care is needed when you have an injury or illness that must be treated within 48 hours. It is usually not life threatening, yet you cannot wait for a routine doctor's office visit. Urgent care is not emergency care.

When you need urgent care after hours, follow these steps:

- Call your PCP. The name and phone number are on your Absolute Total Care member ID card. Your PCP must provide coverage 24 hours a day, seven days a week. You may be connected to an answering service, a nurse on call, your PCP, or another provider authorized by your PCP.
- You can also call our 24/7 nurse advice line at 1-866-433-6041 (TTY: 711). You will be connected to a nurse. Have your Absolute Total Care member ID card number handy.

The nurse may direct you to other care. The nurse may help you over the phone. You may have to give the nurse your phone number.

If you are told to see another doctor or go to the nearest emergency room, bring your Absolute Total Care member ID card and Medicaid ID card. Ask the doctor to call your PCP or Absolute Total Care.

Emergency Care

An emergency is when you have severe pain, illness, or injury. It could result in danger to you. Call 911 right away if you have an emergency or go to the nearest emergency room. You do not need a doctor's or Absolute Total Care's prior approval to get emergency care. If you are not sure if it is an emergency, call your PCP. Your PCP will tell you what to do. If your PCP is not available, a doctor taking calls can help. There may be a message telling you what to do.

Absolute Total Care members can use any hospital or other appropriate setting for emergency services. It is okay if the hospital does not belong to Absolute Total Care's network. Just call us as soon as you can. We will help you get follow-up care. Call Absolute Total Care at 1-866-433-6041 (TTY: 711).

Emergency rooms are for emergencies. If you are not sure if it is an emergency, call your PCP. Your PCP will tell you what to do. Your PCP must provide coverage 24 hours a day, seven days a week. You may be connected to an answering service, a nurse on call, your PCP, or another provider authorized by your PCP. You can also call our 24/7 nurse advice line at 1-866-433-6041 (TTY: 711).

Post-Stabilization Care

Post-stabilization care refers to the services that you get after emergency medical care to maintain, improve or resolve your condition. Absolute Total Care covers this type of service.

Absolute Total Care covers:

- Post-stabilization care services that are provided by a network or non-network provider that are pre-approved by an Absolute Total Care provider or other Absolute Total Care representative.
- Post-stabilization care services that are provided by a network or non-network provider that are not pre-approved by an Absolute Total Care provider or other Absolute Total Care representative, but provided to maintain, improve, or resolve the member's stabilized condition within one hour of a request to Absolute Total Care for pre-approval of further post stabilization care services.
- Post-stabilization care services that are provided by a network or non-network provider that are not pre-approved by an Absolute Total Care provider or other Absolute Total Care representative, but administered to maintain, improve, or resolve the member's stabilized condition if Absolute Total Care:

    - Receives a valid request and/or notification of the need to approve potentially urgent services but does not respond to a request for pre-approval within one (1) hour.
    - Cannot be contacted, and the treating provider can provide evidence of the failed attempts corroborating that reasonable effort was made, but unsuccessful, to contact Absolute Total Care; or
    - The Absolute Total Care representative and the treating provider cannot reach an agreement concerning the member's care, and an Absolute Total Care physician is not available for consultation. Absolute Total Care must give the treating provider the opportunity to consult with an Absolute Total Care physician, and the treating provider may continue with the care of the member until an Absolute Total Care physician is reached.
- Transfer of a member presenting for emergency care to another medical facility.

Absolute Total Care's coverage for post-stabilization care services that are not pre-approved ends when:

- An Absolute Total Care provider with privileges at the treating hospital assumes responsibility of the member's care;
- An Absolute Total Care provider assumes responsibility of the member's care through transfer;
- An Absolute Total Care representative and the treating provider reach agreement concerning the member's care; or
- The member is discharged.

Once the member's emergency medical condition is stabilized, Absolute Total Care requires authorization for hospital admission or prior authorization for follow-up care.

How to Get Medical Care When You Are Out of the Service Region

If you are out of the area and have an emergency, go to the nearest emergency room or call 911. Show your Absolute Total Care member ID card. Be sure to call Absolute Total Care and report your emergency within 48 hours. If you are away and have an urgent problem, go to an urgent care clinic. You may go to any primary care doctor where you are. Be sure to show your Medicaid ID card and your Absolute Total Care member ID card.

Out-of-Network Care

Absolute Total Care realizes that there may be times when you need care from a doctor who is not in Absolute Total Care's provider network. These services can be arranged if medically necessary. Please contact your Absolute Total Care doctor to discuss these needs. Absolute Total Care will approve medical services to an out-of-network doctor if these services are not

available in-network and are medically necessary, as determined by your doctor and Absolute Total Care.

MEMBER GRIEVANCES AND APPEALS

Filing a Grievance

We hope our members are always satisfied with Absolute Total Care and our providers. If you are not satisfied, you have the right to file a grievance. A grievance is an expression of dissatisfaction about any matter other than an adverse benefit determination, such as:

- Wait time to see a doctor
- Being treated unfairly by office staff
- Unclean facilities

You have the right to file a grievance. A grievance may be filed at any time. If you need assistance with your grievance, please call Absolute Total Care at 1-866-433-6041 (TTY: 711) and we will assist you in filing your grievance. This includes providing assistance with accessing interpreter services and hearing-impaired services, if needed, at no cost to you. We cannot and will not treat you differently because you have filed a grievance. Your benefits are not affected.

Who Can File a Grievance?

- An Absolute Total Care member or a member's authorized representative.
    - An authorized representative is a person or provider a member gives the right to act on their behalf.
    - The member can give permission for a person or a provider to act on their behalf in writing or by completing the Appointment of Authorized Representative Form found on our website, absolutetotalcare.com.

How to File a Grievance:

- Call Member Services at 1-866-433-6041 (TTY: 711).
- Mail, email, or fax a completed Grievance Form or written letter telling us why you are not satisfied. You can obtain a Grievance Form from our website, absolutetotalcare.com. Be sure to include:

    - Your first and last name.
    - Your Absolute Total Care member ID card number.
    - Your address and telephone number.
    - The reason for your grievance.

Mail: Absolute Total Care
Grievance and Appeals Coordinator
100 Center Point Circle, Suite 100
Columbia, SC 29210
Fax: 1-866-918-4457
Email: atc-appeals_grievances@centene.com

- Present your evidence in person at the address above.

When Will Absolute Total Care Tell Me the Decision About My Grievance?
Absolute Total Care will send you a letter telling you that we received your grievance within **five calendar days.** We will try to make a decision right away. Sometimes we can resolve it over the phone. If not, we send you a written decision within **90 calendar days** after we get your grievance.

Absolute Total Care may extend the time frame to resolve the grievance up to **14 calendar days** if:

- You or your authorized representative requests an extension; or
- Absolute Total Care can demonstrate that there is a need for additional information that is in the member's best interest.

If an extension is made to your grievance, we contact you and your provider promptly by phone to let you know of our decision. We also send you a letter within **two calendar days** that includes the reason for the extension and your right to file a grievance if you disagree with our decision.

All clinically urgent grievances are determined and reviewed by a medical director and resolved within 72 hours of receipt by Absolute Total Care.

If you are not satisfied with the first decision of the grievance, you can request a second review of your grievance within **30 calendar days** from the receipt of the notice of the original decision. A second review grievance is sometimes called a "*non-coverage*" or "*non-benefit*" appeal. Absolute Total Care reviews your grievance again. The second grievance review is completed by someone who did not make the decision on the first grievance review. After the first and second review of the grievance have been completed, you do not have the right to file a State Fair Hearing.

Filing an Appeal

If you don't agree with a decision, or an adverse benefit determination, we make about services or payment, you have the right to appeal. An appeal is when you request Absolute Total Care to review an adverse benefit determination made by Absolute Total Care. This review makes us look again at the adverse benefit determination. An adverse benefit determination is when Absolute Total Care:

- Denies or limits a requested service.
- Reduces, suspends, or terminates a service that has already been approved.
- Denies payment for a service.
- Fails to provide services in a timely manner, as defined by the state.
- Fails to act within the time frames provided.
- Denies a member, who is a resident of a rural area where there is only one managed care organization (MCO), and requests to exercise his or her right to obtain services outside Absolute Total Care's network.
- Denies a request to dispute financial liability, including cost-sharing, copayments, premiums, deductibles, and coinsurance.

You will know that Absolute Total Care made an adverse benefit determination because we send you an Adverse Benefit Determination Notice. If you do not agree with the adverse benefit determination, you may request an appeal. The Adverse Benefit Determination Notice explains the appeals process and includes a copy of the Appeal Form. Information on the appeals process and a copy of the Appeal Form can also be found on our website at absolutetotalcare.com.

An appeal may be filed within **60 calendar days** from the date on the Adverse Benefit Determination Notice. If you need assistance with your appeal, please call Absolute Total Care at 1-866-433-6041 (TTY: 711). This includes providing assistance with accessing interpreter services and hearing-impaired services, if needed, at no cost to you.

Who Can File an Appeal?

- An Absolute Total Care member or a member's authorized representative.
    - An authorized representative is a person or a provider a member gives the right to act on their behalf.
- The member can give permission for a person or a provider to act on their behalf in writing or by completing the Appointment of Authorized Representative Form found on our website at absolutetotalcare.com.

There Are Two Kinds Of Appeals:

Standard Appeal – We will give you a written decision within **30 calendar days** from the date of receipt of your request.

Expedited Appeal – You can ask for an expedited (or fast) appeal if you or your doctor believe(s) your physical or mental health could be seriously harmed by waiting up to 30 calendar days for a decision. We will give you a written decision within **72 hours** from the date of receipt of your request. We will attempt to notify you and your provider promptly by phone.

Contact our Grievance and Appeals Coordinator at 1-866-433-6041 (TTY: 711) if you think you need an expedited appeal.

If your request for an expedited appeal is denied, we contact you and your provider promptly by phone. We also send you a written notice within **two calendar days** of receiving your expedited appeal request. Absolute Total Care lets you know that your request will be processed as a standard appeal and your right to file a grievance if you disagree with the decision. We will then give you a written decision within **30 calendar days** of the date of the appeal request.

Absolute Total Care may extend the time frame to resolve a standard or an expedited appeal up to **14 calendar days** if:

- You or your authorized representative request an extension; or
- Absolute Total Care can demonstrate that there is a need for additional information that is in the member's best interest.

If an extension is made to your appeal, we contact you and your provider promptly by phone to let you know of our decision. We also send you a letter within **two calendar days** that includes the reason for the extension and your right to file a grievance if you disagree with our decision.

Your appeal is reviewed by a medical director or appropriately licensed professional who was not involved in the prior decision, does not report to the prior-decision maker, and makes the final decision for your appeal request.

How to File an Appeal:

- Call Member Services at 1-866-433-6041 (TTY: 711).
- Mail, email, or fax a completed Appeal Form or a letter about your appeal. You can obtain an Appeal Form from our website, absolutetotalcare.com. A copy of the Appeal Form is also included with your Adverse Benefit Determination Notice. Be sure to include:

    - Your first and last name
    - Your Absolute Total Care member ID card number
    - Your address and telephone number
    - The reason for your appeal

    Mail: Absolute Total Care
    Grievance and Appeals Coordinator
    100 Center Point Circle, Suite 100
    Columbia, SC 29210
    Fax: 1-866-918-4457
    Email: atc-appeals_grievances@centene.com
- Present your evidence in person at the address above.

Absolute Total Care sends you a letter letting you know that we received your appeal.

You have the right to submit comments, evidence, testimony, documentation, records, and other information relevant to the appeal in person, in writing, or by phone. You also have the right to review any evidence and documents regarding your appeal in person at Absolute Total Care's office address listed above. There is limited time to exercise these rights for expedited appeals.

Member Rights to a State Fair Hearing

If you are still not satisfied with the final appeal decision, you or your authorized representative may request a State Fair Hearing from SCDHHS Division of Appeals and Hearings. The request for a State Fair Hearing must be made within **120 calendar days** from the date on the Adverse Benefit Determination Notice. The appeal process must be exhausted before you or your authorized representative may file for a State Fair Hearing.

A request for a hearing must be in writing. Send this request to:

South Carolina Department of Health and Human Services
Division of Appeals and Hearings (Suite 901)
P.O. Box 8206
Columbia, SC 29202-8206
1-803-898-2600

Who Will Attend the State Fair Hearing?
A member or member's authorized representative will attend the State Fair Hearing. A representative from Absolute Total Care also attends.

Continuation of Benefits While an Appeal or State Fair Hearing are Being Decided

You may ask to keep getting care related to your appeal while we make our decision. You or your authorized representative can request to continue to receive the care within **10 calendar days** of the date on Absolute Total Care's Adverse Benefit Determination Notice or the intended effective date of Absolute Total Care's proposed adverse benefit determination. A provider cannot request the continuation of services for you.

Absolute Total Care must continue the benefits if:

- You or your authorized representative files the appeal timely
- A provider cannot request continuation of benefits for you.
- The adverse benefit determination reduces, suspends, or terminates a service that has already been approved
- The services were ordered by an authorized provider
- The original period covered by the original authorization has not expired' or

- You requested a continuation of benefits timely

If Absolute Total Care continues or reinstates the care at your request while the appeal is pending, the care must be continued until one of the following occurs:

- The member withdraws the appeal request
- Ten calendar days pass after the date on the Adverse Benefit Determination Notice providing the resolution of the appeal, unless the member, within the 10-day time frame, has requested a State Fair Hearing with continuation of benefits until a State Fair Hearing decision is reached
- A State Fair Hearing officer issues a decision adverse to the member
- The time period or service limits of a previously authorized service has been met

If the final resolution of the appeal decision is not in your favor, you may have to pay for the cost of the services furnished while the appeal resolution was pending.

Ombudsman

You have the right to be represented in the appeal process by anyone you choose, including an attorney, but representation is not required. The state of South Carolina can provide representation through its Health Insurance Ombudsman Office if you wish to use the service. To contact the service, call 803-734-5049, or mail the South Carolina Office of Ombudsman, Wade Hampton Building, 1205 Pendleton Street, Columbia, SC 29201.

FRAUD, WASTE, AND ABUSE

Absolute Total Care is committed to preventing, detecting, identifying, and reporting suspected cases of fraud, waste, and abuse. We look to our members to assist us in these matters. If you happen to witness, are told of, or suspect an incident of fraud, waste or abuse, it is important to report this immediately to Absolute Total Care or to the SCDHHS Division of Program Integrity 1-888-364-3224.

What is Fraud?

Fraud means to knowingly get benefits or payments that you are not entitled to receive. Please let us know if you are aware of someone who is committing fraud. This could be a doctor or a member.

Some examples of healthcare fraud include but are not limited to:

- A lie on an application.
- Using someone else's member ID card.
- A doctor billing for services that you did not get.

Absolute Total Care Fraud, Waste, and Abuse Reporting Contact Information
Mail:
Absolute Total Care
Compliance Department
100 Center Point Circle, Suite 100
Columbia, SC 29210

Absolute Total Care Fraud and Abuse Hotline: 1-866-685-8664 (All calls are confidential.)

Email: ATC.Compliance@centene.com

South Carolina Department of Health and Human Services (SCDHHS) Fraud, Waste, and Abuse Reporting Contact Information
Mail:
SCDHHS Division of Program Integrity
P.O. Box 8206
Columbia, SC 29202

Phone: 1-888-364-3224

Email: fraudres@scdhhs.gov

Absolute Total Care's staff is available to answer any questions or concerns you have regarding fraud, waste and abuse issues. Please contact Absolute Total Care's Member Services Department at 1-866-433-6041 (TTY: 711) with any questions.

CLAIMS

Your provider is required to submit claims on your behalf for each service you receive. They can do this electronically or by mail.

NEWBORN ENROLLMENT

Your newborn child will also be enrolled in Absolute Total Care. Your baby will stay with Absolute Total Care for the remainder of the enrollment year, unless you change to another health plan during the second or third month of your baby's life. If you do change to a new health plan, your baby will be moved to the new plan with you unless you want your baby to stay on Absolute Total Care's plan.

Please call SCDHHS at 1-888-549-0820 to be sure your baby is properly enrolled with Absolute Total Care.

DISENROLLMENT

You can disenroll and change health plans without a cause. Without a cause means you do not need a reason for the request. You may ask to disenroll without a cause:

- Once within the first 90 days of membership.
- Every 12 months.
- If Medicaid eligibility is lost for a period of 60 days or less and you are reenrolled with Absolute Total Care.
- SCDHHS imposes a sanction against Absolute Total Care that allows members to request disenrollment without a cause.

You may request to disenroll from Absolute Total Care and choose another health plan at any time for cause. This means you need a reason for the request.

Reasons why Members May Request to Disenroll For Cause at Any Time:

- Member moves out of Absolute Total Care's service area.
- Absolute Total Care no longer participates in the South Carolina Healthy Connections Program.
- Poor quality of care or lack of access to covered services or providers experienced in dealing with the member's healthcare needs.

To disenroll, call South Carolina Healthy Connections Choices toll-free at 1-877-552-4642 (TTY: 1-877-552-4670) and ask to speak with an Enrollment Counselor who will send you the appropriate form for completion. You may also visit the website, www.scchoices.com, for more information. You should contact Absolute Total Care before submitting the completed form to the Enrollment Broker. All disenrollment requests for cause must be approved by SCDHHS. If you ask to disenroll for cause and it is not approved, you have the right to request a State Fair Hearing regarding the decision.

Reasons why Absolute Total Care May Request Member Disenrollment at Any Time:

- Absolute Total Care no longer participates in the South Carolina Healthy Connections Program or in the member's service area.
- Member intentionally submits fraudulent information.
- Death of a member.
- Member moves out of state or out of Absolute Total Care's service area.
- Member is enrolled in a commercial managed care health plan.
- Member is placed out of home (for example, Intermediate Care Facility for Individuals with Intellectual Disabilities [ICR/IID]).
- Member becomes an inmate of public institution such as prison.

-
- Member's behavior is disruptive, unruly, abusive, or uncooperative and impairs Absolute Total Care's ability to furnish services to the member or other members.

ADVANCE DIRECTIVES

Advance Directives are written instructions about the healthcare you want to receive if you are unable to speak for yourself. Any Absolute Total Care member 18 years or older can make an Advance Directive to accept or refuse medical or surgical treatment or withhold or remove life-giving care in the event of a terminal condition. This also includes planning treatment before you need it.

Advance directives can be general, with very few directions about your care. The directive may just name a substitute person (proxy) to make these decisions for you if you are unable to do so. Or it may include instructions for the chosen proxy.

Advance directives can also be very detailed and can clearly outline decisions concerning your medical care, including medical or surgical treatments you would accept or refuse in certain situations. Some types of advance directives are limited to certain situations, like the living will, organ or tissue donation, or your wishes not to be revived (resuscitated) if your heart or breathing stops.

It can help your doctors understand your wishes about your health. Advance Directives will not take away your right to make your own decisions. They will work only when you are unable to speak for yourself. An advance directive is a way to put those wishes on record for your family, your heirs, and your healthcare provider.

Absolute Total Care recommends all our members take the time to create an Advance Directive and with your healthcare proxy, your doctors and other healthcare providers, family members and friends, and your attorney, if you have one. You should also store the original in a safe place. You will not be treated differently for not having an Advance Directive. Absolute Total Care does not limit the implementation of Advance Directives as a matter of conscience.

No matter which kind you use, no one will be able to control your money or other property based on your advance directive. It may also help to know that you can also change or revoke (take back) these directives at any time.

Examples of Advance Directives include:

- Living Will
- Health Care Power of Attorney

- "Do Not Resuscitate" Orders

Use an Advance Directive if:

- You want to spell out your healthcare wishes.
- You want a complete estate plan.
- You have recently been diagnosed with a serious disease.
- You have strong convictions about life support or other healthcare choices.

For Assistance with Advance Directives, You May:

- Talk to your doctor.
- Talk to an attorney.
- Contact the South Carolina Department on Aging at 1-800-868-9095 or 1-803-734-9900 or visit aging.sc.gov online for assistance.:
- Visit CaringInfo.org for a copy of the South Carolina Advance Directive Planning for Important Healthcare Decisions Guide.
- Visit AgingWithDignity.org if you want the Five Wishes Form.

If Your Advance Directives are not Being Followed, do any of the Following:

- Talk to your doctor.
- Call the South Carolina Department of Public Health at 803-898-3300 to file a complaint.
- Call Member Services at 1-866-433-6041 (TTY: 711). A representative will help you file your complaint with the South Carolina Department of Public Health.

MEMBER RIGHTS

Members are informed of their rights and responsibilities through the Member Handbook. Absolute Total Care providers are also expected to respect and honor members' rights.

Absolute Total Care members have the following rights and responsibilities:

- To be treated with respect and with due consideration for his or her dignity and the right to privacy and non-discrimination as required by law.
- To participate with their providers and practitioners in making decisions regarding their healthcare, including the right to refuse treatment.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in the federal regulations on the use of restraints and seclusion.
- To request and receive a copy of their medical records, and request that their medical records be amended or corrected.

- To receive healthcare services that are accessible, are comparable in amount, duration and scope to those provided under Medicaid Fee-For-Service and are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished.
- To receive services that are appropriate and are not denied or reduced solely because of diagnosis, type of illness, or medical condition.
- To receive all information including enrollment notices, information materials, instructional materials, available treatment options, and alternatives in a manner and format that may be easily understood.
- To receive assistance from both SCDHHS and Absolute Total Care in understanding the requirements and benefits of the health plan.
- To receive oral interpretation services free of charge for all non-English languages, not just those identified as prevalent.
- To be notified that oral interpretation is available and how to access those services.
- To receive information about the basic features of managed care, which populations may or may not enroll in the program, and Absolute Total Care's responsibilities for coordination of care in a timely manner to make an informed choice.
- To receive information on the following:
    - *Benefits covered.*
    - *Procedures for obtaining benefits, including any authorization requirements*
    - *Cost-sharing requirements.*
    - *Service area.*
    - *Names, locations, telephone numbers of non-English language speaking Absolute Total Care providers, including at a minimum, PCPs, specialists, and hospitals.*
    - *Any restrictions on the member's freedom of choice among network providers.*
    - *Providers not accepting new patients.*
    - *Benefits not offered by Absolute Total Care but available to members, and how to obtain those benefits, including how transportation is provided.*
- To receive a complete description of disenrollment rights at least annually.
- To receive notice of any significant changes in the Benefits Package at least 30 days before the intended effective date of the change.
- To receive information on the grievance, appeal, and State Fair Hearing procedures.
- To receive detailed information on emergency and after-hours coverage, including, but not limited to:
    - *What constitutes an emergency medical condition, emergency services, and post-stabilization services.*
    - *That emergency services do not require prior authorization.*
    - *The process and procedures for obtaining emergency services.*
    - *The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under the contract.*
    - *The right to use any hospital or other setting for emergency care.*

    - *Post-stabilization care services rules in accordance with federal guidelines.*
- To expect their medical records and care be kept confidential as required by law.
- To receive Absolute Total Care's policy on referrals for specialty care and other benefits not provided by the member's PCP.
- Privacy of healthcare needs and information as required by federal law (Standards for Privacy of Individually Identifiable Health Information).
- To exercise these rights without adversely affecting the way Absolute Total Care, its providers, or SCDHHS treat the member.
- To allow or refuse their personal information, be sent to another party for other uses unless the release of information is required by law.
- To receive timely access to care, including referrals to specialists when medically necessary without barriers.
- To choose a PCP and to change to another PCP.
- To choose a person to act on their behalf.
- To voice grievances or file appeals about Absolute Total Care decisions that affect their privacy, benefits, or the care provided.
- To make recommendations regarding Absolute Total Care's member rights and responsibilities policy.
- File for a State Fair Hearing with SCDHHS.
- To make an advance directive, such as a living will.
- To receive information about Absolute Total Care, its benefits, its services, its practitioners, providers, and member rights and responsibilities.
- To have a candid discussion about appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- To get a second opinion from a qualified healthcare professional.
    - *You have the right to a second opinion about your care.*
    - *This means talking to a different provider about an issue to see what they have to say. The second provider is able to give you their point of view. This may help you decide if certain services or methods are best for you. If you want to hear another point of view, tell your PCP.*
    - *Choose an Absolute Total Care contracted provider to give you a second opinion. There is no charge to you. Your PCP or Member Services can help you find a provider. If you are unable to find a provider in Absolute Total Care's network, we will help you find a provider outside the network. There is no charge to you if you need a second opinion from a provider outside the network.*
    - *Any tests that are ordered for a second opinion must be given by a provider in Absolute Total Care's network. Your PCP will look at the second opinion and help you decide on a treatment plan that will work best for you.*

MEMBER RESPONSIBILITIES

Absolute Total Care members have the following responsibilities:

- To inform Absolute Total Care of the loss or theft of their ID card.
- To present their ID card when using healthcare services.
- To be familiar with Absolute Total Care procedures to the best of their ability.
- To call or contact Absolute Total Care to obtain information and have questions clarified.
- To provide information (to the extent possible) that Absolute Total Care and its practitioners and providers need to provide care.
- To follow the prescribed treatment (plans and instructions) for care that has been agreed upon with their practitioners/providers.
- Make every effort to keep a scheduled appointment or cancel an appointment in advance of when it is scheduled.
- To inform their provider of reasons they cannot follow the prescribed treatment of care recommended.
- To understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible.
- To access preventive care services.
- To follow the policies and procedures of the SCDHHS Medicaid Plan.
- To be honest with providers and treat them with respect and kindness.
- To get regular medical care from their PCP before seeing a specialist.
- To follow the steps of the appeal process.
- To notify SCDHHS, Absolute Total Care and your providers of any changes that may affect their membership, healthcare needs or access to benefits. Some examples may include:
    - *If they have a baby.*
    - *If their address changes.*
    - *If their telephone number changes.*
    - *If they or one of their children are covered by another health plan.*
    - *If they have a special medical concern.*
    - *If their family size changes.*
- To keep all their scheduled appointments, be on time for those appointments, and cancel 24 hours in advance if they cannot keep an appointment.

Additional Responsibilities

Absolute Total Care members are also responsible for notifying Absolute Total Care immediately of the following:

- Any workers' compensation claim.

- Any pending personal injury or medical malpractice lawsuit.
- Any involvement in an auto accident.
- Any other health insurance policy (including employer-sponsored insurance) that the member has or obtains.

YOUR RIGHTS

Medical Records

Each physician's office keeps a copy of your medical records. If you are a new member, we encourage you to transfer your previous medical records to your PCP's office. Transferring your records to your PCP's office will give your PCP easier access to your medical history. Your previous physician may charge you a fee for this transfer of records. Your medical records are kept in confidence and will only be released as authorized by law. Please refer to the Privacy Notice in this handbook for our guidelines on the release of medical information.

If you need help, contact Member Services at 1-866-433-6041 (TTY: 711). We will instruct you on the forms you need to authorize your provider to release medical information.

Your Civil Rights

Absolute Total Care provides covered services to all members without regard to:

- Age
- Health status or need for healthcare
- Creed
- Ancestry
- Culture
- Physical or mental disability
- Marital status
- Race
- Sex
- Arrest or Conviction
- Religion
- Sexual orientation
- Color
- National origin
- Gender identity

All services that are covered and medically necessary may be obtained. All services are provided in the same way to all members. Absolute Total Care providers who refer members for care do so the same way for all. Translation services are available if you need them. This includes sign language. This service is free.

Digital Health Records

Your Health Information

Federal rules give you more control of your health information. You can use safe apps and tools to view some of your health records. You can also share them. This can help you, your doctors, and your health plans give you care.
Your health information may include:

- Claims that were paid or denied
- Facts about your medicine
- Health records kept by your health plan
- Facts about your doctors and other care staff
- Prior approval facts, such as if a request was approved

Some records may be ready for care you got on or after January 1, 2016. Rules may limit how long records are kept.

Your Choices for Sharing Health Information

You can choose how your health records are shared. Use the Consent Management tool in your secure member portal, visit https://www.absolutetotalcare.com/login.html

Sharing with Health Apps

You may link an approved health app to your health records. You can check the app's access at any time. You can also stop or change its access. Use your secure member portal.

Sharing Between Health Plans

You may change health plans. You may also have more than one plan at a time. You can let your health plans share health records. This may include claims, health records, and prior approval facts. Your health plans need your consent before they can share your records. You can start, stop, or change this sharing at any time. Use your secure member portal.

Sharing with Your Doctors

Your doctors and care staff may be able to view your health records. This can help them plan your care. You can check or change this choice at any time. Use your sure member portal.

Change Your Choices at Any Time

The Consent Management tool lets you:

- Manage sharing between health plans
- Manage sharing with your doctors and care staff
- Manage sharing with approved health apps

You can change these choices at any time. A change will apply to future sharing. It will not remove records shared before the change.

For more information, visit [Insert link to interoperability member educational materials website URL].

PROTECTING YOUR PRIVACY

Absolute Total Care
Notice of Privacy Practices

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

Effective 1/1/2026

For help to translate or understand this, please call 1-866-433-6041 (TTY: 711).
Si necesita ayuda para traducir o entender este texto, por favor llame al telefono.
1-866-433-6041 (TTY: 711).

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

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

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

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

We will make any revised Notices available on our website or through a separate mailing.

Internal Protections of Oral, Written and Electronic PHI:

Absolute Total Care protects your PHI. We are also committed to keeping your race, ethnicity and language (REL) and sexual orientation and gender identity (SOGI) information confidential. We have privacy and security processes to help.

These are some of the ways we protect your PHI:

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

Permissible Uses and Disclosures of Your PHI:
The following is a list of how we may use or disclose your PHI without your permission or authorization:

- **Treatment.** We may use or disclose your PHI to a physician or other healthcare provider providing treatment to you, to coordinate your treatment among providers, or to assist us in making prior authorization decisions related to your benefits.
- **Payment.** We may use and disclose your PHI to make benefit payments for the healthcare services provided to you. We may disclose your PHI to another health plan, to a healthcare provider or other entity subject to the federal Privacy Rules for payment purposes. Payment activities may include processing claims, determining eligibility or coverage for claims, and reviewing services for medical necessity.
- **Healthcare Operations.** We may use and disclose your PHI to perform our healthcare operations. These activities may include providing customer service, responding to complaints and appeals, and providing care management and care coordination.

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

  - Quality assessment and improvement activities
  - Reviewing the competence or qualifications of healthcare professionals
  - Care management and care coordination
  - Detecting or preventing healthcare fraud and abuse

  Your race, ethnicity, language, sexual orientation and gender identity are

protected by the health plan's systems and laws. This means information you provide is private and secure. We can only share this information with health care providers. It will not be shared with others without your permission or authorization. We use this information to help improve the quality of your care and services.
This information helps us to:

- Better understand your healthcare needs.
- Know your language preference when seeing healthcare providers.
- Providing healthcare information to meet your care needs.
- Offer programs to help you be your healthiest.

This information is not used for underwriting purposes or to make decisions about whether you are able to receive coverage or services.

Other Permitted or Required Disclosures of Your PHI:

- ***Fundraising Activities*** – We may use or disclose your PHI for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance their activities. If we do contact you for fundraising activities, we will give you the opportunity to opt-out, or stop, receiving such communications in the future.
- ***Underwriting Purposes*** – We may use or disclose your PHI for underwriting purposes, such as to make a determination about a coverage application or request. If we do use or disclose your PHI for underwriting purposes, we are prohibited from using or disclosing your PHI that is genetic information in the underwriting process.
- ***Appointment Reminders/Treatment Alternatives*** - We may use and disclose your PHI to remind you of an appointment for treatment and medical care with us or to provide you with information regarding treatment alternatives or other health-related benefits and services, such as information on how to stop smoking or lose weight.
- ***As Required by Law*** - If federal, state, and/or local law requires a use or disclosure of your PHI, we may use or disclose your PHI information to the extent that the use or disclosure complies with such law and is limited to the requirements of such law. If two or more laws or regulations governing the same use or disclosure conflict, we will comply with the more restrictive laws or regulations.
- ***Public Health Activities*** - We may disclose your PHI to a public health authority for the purpose of preventing or controlling disease, injury, or disability. We may disclose your PHI to the Food and Drug Administration (FDA) to ensure the quality, safety or effectiveness of products or services under the jurisdiction of the FDA.
- ***Victims of Abuse and Neglect*** - We may disclose your PHI to a local, state, or federal government authority, including social services or a protective services agency authorized by law to receive such reports if we have a reasonable belief of abuse, neglect or domestic violence.

- ***Judicial and Administrative Proceedings*** - We may disclose your PHI in response to an administrative or court order. We may also be required to disclose your PHI to respond to a subpoena, discovery request, or other similar requests.
- ***Law Enforcement*** - We may disclose your relevant PHI to law enforcement when required to do so for the purposes of responding to a crime.
- ***Substance Use Disorder Records (SUD)*** – We will not use or disclose your SUD records in legal proceedings against you unless:
    - We receive your written consent, or
    - We receive a court order, you've been made aware of the request and been given a chance to be heard. The court order must include a subpoena or similar legal document requiring a response.
- ***Coroners, Medical Examiners and Funeral Directors*** - We may disclose your PHI to a coroner or medical examiner. This may be necessary, for example, to determine a cause of death. We may also disclose your PHI to funeral directors, as necessary, to carry out their duties.
- ***Organ, Eye and Tissue Donation*** – We may disclose your PHI to organ procurement organizations. We may also disclose your PHI to those who work in procurement, banking or transplantation of cadaveric organs, eyes, and tissues.
- ***Threats to Health and Safety*** - We may use or disclose your PHI if we believe, in good faith, that the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.
- ***Specialized Government Functions*** - If you are a member of U.S. Armed Forces, we may disclose your PHI as required by military command authorities. We may also disclose your PHI to authorized federal officials for national security concerns, intelligence activities, The Department of State for medical suitability determinations, the protection of the President, and other authorized persons as may be required by law.
- ***Workers' Compensation*** - We may disclose your PHI to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.
- ***Emergency Situations*** – We may disclose your PHI in an emergency situation, or if you are incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previously identified by you. We will use professional judgment and experience to determine if the disclosure is in your best interest. If the disclosure is in your best interest, we will only disclose the PHI that is directly relevant to the person's involvement in your care.
- ***Inmates*** - If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your PHI to the correctional institution or law enforcement official, where such information is necessary for the institution to provide you with health care; to protect your health or safety; or the health or safety of others; or for the safety and security of the correctional institution.
- ***Research*** - Under certain circumstances, we may disclose your PHI to researchers when their clinical research study has been approved and where certain safeguards are in place to ensure the privacy and protection of your PHI.

Uses and Disclosures of Your PHI that Require Your Written Authorization:

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

- ***Sale of PHI*** – We will request your written authorization before we make any disclosure that is deemed a sale of your PHI, meaning that we are receiving compensation for disclosing the PHI in this manner.
- ***Marketing*** – We will request your written authorization to use or disclose your PHI for marketing purposes with limited exceptions, such as when we have face-to-face marketing communications with you or when we provide promotional gifts of nominal value.
- ***Psychotherapy Notes*** – We will request your written authorization to use or disclose any of your psychotherapy notes that we may have on file with limited exception, such as for certain treatment, payment or healthcare operation functions.

You have the right to revoke your authorization, in writing at any time except to the extent that we have already used or disclosed your PHI based on that initial authorization.

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

- ***Right to Request Restrictions*** **-** You have the right to request restrictions on the use and disclosure of your PHI for treatment, payment, or healthcare operations, as well as disclosures to persons involved in your care or payment of your care, such as family members or close friends. Your request should state the restrictions you are requesting and state to whom the restrictions apply. We are not required to agree to this request. If we agree, we will comply with your restriction request unless the information is needed to provide you with emergency treatment. However, we will restrict the use or disclosure of PHI for payment or health care operations to a health plan when you have paid for the service or item out of pocket in full.
- ***Right to Request Confidential Communications*** **-** You have the right to request that we communicate with you about your PHI by alternative means or to alternative locations. This right only applies if the information could endanger you if it is not communicated by the alternative means or to the alternative location you want. You do not have to explain the reason for your request, but you must state that the information could endanger you if the communication means or location is not changed. We must accommodate your request if it is reasonable and specifies the alternative means or location where your PHI should be delivered.
- ***Right to Access and Receive a Copy of your PHI*** **-** You have the right, with limited exceptions, to look at or get copies of your PHI contained in a designated record set. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so**.** You must make a request in writing to obtain access to your PHI. If we deny your request, we will provide you a written explanation and will tell you if the reasons for the denial can be reviewed. We will also tell you how to ask for such a review or if the denial cannot be reviewed.

- ***Right to Amend your PHI*** **-** You have the right to request that we amend, or change, your PHI if you believe it contains incorrect information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request for certain reasons, for example if we did not create the information you want amended and the creator of the PHI is able to perform the amendment. If we deny your request, we will provide you a written explanation. You may respond with a statement that you disagree with our decision and we will attach your statement to the PHI you request that we amend. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.
- ***Right to Receive an Accounting of Disclosures*** **-** You have the right to receive a list of instances within the last 6-year period in which we or our business associates disclosed your PHI. This does not apply to disclosure for purposes of treatment, payment, health care operations, or disclosures you authorized and certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. We will provide you with more information on our fees at the time of your request.
- ***Right to File a Complaint*** **-** If you feel your privacy rights have been violated or that we have violated our own privacy practices, you can file a complaint with us in writing or by phone using the contact information at the end of this Notice.

  You can also file a complaint with the Secretary of the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201 or calling **1-800-368-1019**, (TTY: **1-800-537-7697**or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints**/.

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

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

Race, Ethnicity, Language, Sexual Orientation and Gender Identity Information
Absolute Total Care is committed to keeping your race, ethnicity language (REL) and sexual orientation and gender identity (SOGI) information confidential. We use some of the following methods to protect your information:

- maintaining paper documents in locked file cabinets
- requiring that all electronic information remain on physically secure media
- maintaining your electronic information in password-protected files

We may use or disclose your REL or SOGI information to perform our operations. These activities may include:

- assessing health care disparities
- designing intervention programs
- designing and directing outreach materials
- informing health care practitioners and providers about your language needs

We never use your REL or SOGI information for underwriting, rate setting or benefit determinations or disclose your REL or SOGI information to unauthorized individuals.

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

Absolute Total Care
Attn: Privacy Official
100 Center Point Circle, Suite 100
Columbia, SC 29210

1-866-433-6041 (TTY: 711)

DEFINITIONS

Definitions to Help You Understand the Member Handbook

Absolute Total Care Member ID Card: A card that identifies you as an Absolute Total Care member.

Advance Directive: Anything you tell people about what you want for your healthcare in the event you are not able to tell them yourself. A living will is the most common advance directive with your PCP.

Adverse Benefit Determination:

- Denial or limitation of a requested service, including determinations based on type or level of service, whether the service is medically needed, appropriateness, setting, or effectiveness of a covered benefit.
- Reduction, suspension, or termination of a service that has already been approved.
- Denial of payment for a service.
- Failure to provide services in a timely manner, as defined by the state.
- Failure to act within the time frames provided.
- Denial of a member, who is a resident of a rural area where there is only one MCO, request to exercise his or her right to obtain services outside Absolute Total Care's network.
- Denial of a request to dispute a financial liability, including cost-sharing, copayments, premiums, deductibles, and coinsurance.

Appeal: A request for review of an Adverse Benefit Determination, as defined in 42 CFR §438.400.

Authorization: A decision to approve special care or other medically necessary care. An authorization can also be called a "referral."

Authorized Representative: An individual granted authority to act for a member with the member's knowledge and written consent and who has knowledge of the circumstances.

Behavioral Health Services: Mental health and substance abuse services.

Benefits/Covered Services: Services, procedures, and medications that Absolute Total Care will cover for you when medically necessary.

Carved-Out Benefits: Services that are not covered by Absolute Total Care. Benefits are covered directly by Medicaid.

Comprehensive Drug List (CDL): A list of medications covered by Absolute Total Care.

Continuity and Coordination of Care: Healthcare provided on a continuous basis beginning with the patient's initial contact with a PCP and following the patient through all episodes. Care that is uninterrupted.

Copayment: Any cost-sharing payment for which the Member is responsible.

Covered Services: Medically necessary services that Absolute Total Care will pay the provider for you to receive.

Critical Incident: A Critical Incident is, at a minimum, verbal, physical, sexual, psychological, or emotional abuse; neglect; exploitation including financial exploitation; misuse or unauthorized use of restrictive interventions or seclusion; a medication error resulting in a telephone call to or a consultation with a poison control center, an emergency department visit, an urgent care visit, a hospitalization, or death; or an unexplained or unanticipated death, including but not limited to a death caused by abuse or neglect. (See 42 CFR § 441.302(a)(6)(i)(A))

Disenrollment: To stop your membership in Absolute Total Care.

Durable Medical Equipment (DME): Equipment that provides therapeutic benefits or enables Beneficiaries to perform certain tasks that they are unable to undertake otherwise due to certain medical conditions and/or illness.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)/Well-Child Program: Provides exams for children through the month of their 21st birthday.

Eligible(s): A person who has been determined eligible to receive services as provided for in the State Medicaid Plan.

Emergency Care: When you have an injury or illness that must be treated immediately or is life threatening.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and/or her unborn child) in serious jeopardy; serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Emergency Services: Covered inpatient and outpatient Services that are provided by a Provider that is qualified to furnish these services and needed to evaluate or stabilize an Emergency Medical Condition.

Excluded Services: Medicaid services not included in Absolute Total Care's core benefits and reimbursed fee-for-service by the state.

Grievance: An expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Possible subjects for Grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a

Provider or employee, or failure to respect the member's rights. Grievance includes a Member's right to dispute an extension of time proposed by the Contractor to make an authorization decision.

Health Insurance Plan: A Health Insurance Plan means a package of covered health care items and services offered to individuals, together with the payment terms applicable to those items and services. The Plan specifies the scope of benefits, the reimbursement amounts or cost-sharing obligations and ensures access to a contracted provider network within the designated service area.

Home and Community Based Services (HCBS): Services delivered to persons with long-term care needs that allow them to remain in a community-based environment, as authorized in an approved 1915(c) Waiver or 1915(i) State Plan.

Home Health Care: Full range of medical and other health-related services that are delivered in the home of a medically home bound patient by a healthcare professional.

Hospice Services: Services in which the Member is provided with palliative care (relief of pain and uncomfortable symptoms) as opposed to curative care for terminally ill individuals.

Hospital Outpatient Services: Hospital outpatient services is treatment received at a hospital or its departments by a patient who has not been formally admitted as an inpatient by a physician. These services are diagnostic, therapeutic, rehabilitative, or palliative items or services that are furnished by or under the direction of a physician or dentist to an outpatient in an institution licensed and certified as a hospital.

Immunizations: Necessary shots to protect you or your child from life threatening diseases.

Inpatient: When you are admitted into a hospital.

Medicaid: The medical assistance program authorized by Title XIX of the Social Security Act.

Medicaid ID Card: A card that identifies you as part of the South Carolina Medicaid Program.

Medical Necessity: Services utilized in the State Medicaid Program, including quantitative and non-quantitative treatment limits, to determine the level of need for medical services rendered, as indicated in State statutes and regulations, the State Plan, and other State policy and Procedures.

Medical Network: An integrated delivery system of healthcare services

Member: A person who is eligible to receive covered services from Absolute Total Care as defined by SCDHHS.

Network Provider: A Provider of healthcare services or products which includes, but is not limited to, an institution, facility, agency, person, corporation, partnership, practitioner, specialty physician, group or association approved and enrolled by the Department, licensed and/or credentialed which accepts payment in full for providing benefits to Members.

Non-Participating Provider: A Provider licensed to practice who has not contracted with or is not employed by Absolute Total Care or Healthy Connections Medicaid to provide health care services.

Outpatient: Preventive, diagnostic, therapeutic, rehabilitative, surgical, mental health, facility services for dental, and Emergency Services received by a patient through an outpatient/ambulatory care facility for the treatment of a disease or injury for a period of time generally not exceeding twenty-four (24) hours.

Post-Stabilization: Post-stabilization care refers to the services that you get after emergency medical care to keep your condition under control.

Premium: A monthly fee that may be paid to Medicare or Medicaid.

Prescription Drugs: Any medication that cannot be purchased over-the-counter and must have a written request from your doctor for you to have it.

Primary Care Provider (PCP): A general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician who serves as the entry point into the healthcare system for the member. The PCP is responsible for providing primary care, coordinating, and monitoring referrals to specialist care, authorizing hospital services and maintaining Continuity of Care.

Prior Authorization: The act of authorizing specific approved services by Absolute Total Care before rendered.

Provider: Any individual or entity furnishing Medicaid services under a Provider agreement with Absolute Total Care or the Medicaid agency. See 42 CFR 400.203. These may include the following: any individual, group, Physicians (e.g. Primary Care Providers and Specialists) or entity (e.g. hospitals, ancillary Providers, outpatient center (free standing or owned) clinics and laboratories) furnishing Medicaid services under an agreement with the SCDHHS; or for the Medicaid Managed Care Program, any individual, group, Physicians (e.g. Primary Care Providers and Specialists) or entity (e.g. hospitals, ancillary Providers, clinics, outpatient centers (free standing or owned) and laboratories) that is engaged in the delivery of health care services and is legally authorized to do so by the state in which it delivers services.

Provider Directory: A list of providers participating with Absolute Total Care.

Referral: The process by which the member's PCP directs him or her to seek and obtain medically necessary, covered services from another healthcare professional.

SCDHHS: South Carolina Department of Health and Human Services.

Self-Referred Services: Services that you do not need to see your PCP for a referral.

Single Preferred Drug List (sPDL): A list of outpatient drugs covered under the Pharmacy Benefit that health care payors use to encourage providers to prescribe certain drugs over others. The sPDL is not a comprehensive list of all medications covered by Medicaid.

Specialist: A healthcare professional with advanced training who treats only certain parts of the body, certain health conditions, or certain age groups, and who is distinct from a Primary Care Provider.

Special Populations: Individuals that may require unique considerations and/or tailored health care services that should be incorporated into a Care Management Plan that guarantees that

the most appropriate level of care is provided for these individuals.

Termination: The member's loss of eligibility for the South Carolina Medicaid MCO program and therefore automatic disenrollment from Absolute Total Care.

Treatment: The care that you may receive from doctors and facilities.

Urgent Care: Medical conditions that require attention within forty-eight (48) hours. If the condition is left untreated for forty-eight (48) hours or more, it could develop into an emergency condition.