MEMBER INFORMATION

MEMBER ELIGIBILITY

The dual eligible demonstration will be available to individuals who meet the following criteria:

- Enrolled in Medicare Part A and B and are receiving full Medicaid benefits
- Age 65+
- Not in an institution (at time of enrollment)
- Not enrolled in a PACE program (Program of All-Inclusive Care for the Elderly)
- Non-Department of Disabilities Special Needs (Non- DDSPN) waiver
- Not a patient in Hospice

You should always verify member eligibility prior to delivering services. It is very important to ask the member for a copy of the health plan ID card and some other form of identification, such as a driver's license or photo ID.

ATC's card replaces the member's original red, white, and blue Medicare card and their Medicaid Fee for Service (FFS) ID card. See below sample ATC member ID card.

Member Identification Card

Eligibility may be verifed in three ways:

1. The Secure Portal found at www.absolutetotalcare.com
   - If you are already a registered user of the Portal, you do not need a separate registration.
   - If you are not currently a registered user, registration is a quick process. There is a video on our registration page which will walk you through the process should you experience any difficulties.
2. 24/7 Interactive Voice Response System: 1-855-735-4398.
3. Provider Services at 1-855-735-4398.

MEMBER BENEFITS

ATC will cover all current/traditional Medicare FFS benefits (including primary and acute care, Part D, and skilled nursing facility services) and current Medicaid FFS (including nursing facilities and behavioral health services and home and community based waiver services) subject to eligibility verification, medical necessity determination and prior authorization requirements. The table below represents the covered benefits offered. This table may not be all-inclusive. Should you have questions regarding benefits, you may call Provider Services at 1-855-735-4398.

Services Offered Under Healthy Connections Prime

Inpatient Hospital Services	Ambulance Services	Family Planning Services	New Benefit
Inpatient Psychiatric Facility Services	Transportation Services[1]	Home and Community Based Waiver Services	Palliative Care: An interdisciplinary practice aimed at improving the quality of life of beneficiaries and their families with advanced illness or life-threatening injury. This benefit provides interventions early in the course of illness to assist with symptom management or advance care planning. It uses of an interdisciplinary team approach to address the comprehensive needs of residents and families.
Skilled Nursing Facility Services	Durable Medical Equipment	Targeted Case Management (TCM)	
Cardiac and Pulmonary Rehab Services	Diabetic supplies and Services and Diabetic Therapeutic Shoes or Inserts	Outpatient Mental Health Services	
Emergency Care	End-Stage Renal Disease services[2]	Telemedicine	
Urgently Needed Care	Nursing Home Transition Services	Preventive Services & Other Defined Supplemental Services	
Partial Hospitalization	Over-the-Counter Items	Medicare-covered Zero Cost-Sharing Preventive Services	
Home Health Benefits	Meal Benefits[3]	Annual Physical Exam	
Primary Care Physician Services	Behavioral Health Services	Supplemental Education/Health Management Programs	
Chiropractic Services	Institution for Mental Disease Services	Supplemental Education/Wellness Programs	
Occupational Therapy	Federally Qualified Health Centers	Kidney Disease Education Services	
Physician Specialist Services excluding Psychiatric Services	Outpatient Diagnostic Procedures and Tests and Lab Services	Diabetes Self-Management Training	
Mental Health Specialty Services	Outpatient Hospital Services	Medicare Part B Rx Drugs and Home Infusion Drugs	
Podiatry	Ambulatory Surgical Center Services	Eye Exams	
Other Health Care Professional Services	Outpatient Substance Abuse Services	Eye Wear	
Psychiatric Services	Outpatient Blood Services	Hearing Exams	
Physical Therapy and Speech-Language Pathology Services	Infusion Centers		

In addition to the table above, ATC also offers the following value added benefits:

- Hearing: Free hearing test per year and up to $750 for a hearing aid every year
- Over-the-Counter Supplies: Certain over-the-counter and personal wellness items shipped free to the member's home from our mail order pharmacy
- Health Club Membership: Up to $250 reimbursement per year for a health club membership fee

MEMBER ORIENTATION

Once the enrollment application is processed, each new member will receive a letter from South Carolina Healthy Connections Medicaid stating the effective date of coverage and a packet of information about our program.

The following documents are provided to the new members:

- ID card
- Welcome Letter
- A comprehensive integrated formulary
- Information about how to access or receive the pharmacy/provider directory
- Summary of Benefits (SB)
- Member Handbook (Evidence of Coverage - EOC)

Members are encouraged to select a health plan contracted PCP. For all members in case management, a case management team will work with the member's PCP or facility personnel to address the needs of the member, coordinate needed healthcare and services and ensure the member accesses their preferred health service benefits.

Members receive various pieces of information through mailings and face-to-face contact. Many of these materials are printed in English and Spanish. These materials include but are not limited to:

- NurseWise Information (our 24/7 Nurse Advice Line)
- Emergency Room Information

Providers interested in receiving these materials may contact the Provider Services Department at 1-855-735-4398.

ENROLLMENT PROCESS

All enrollment and disenrollment related transactions, including enrollments from one CICO to a different CICO, will be processed by Maximus. Eligibility and enrollment is determined by the State or its enrollment broker/vendor based on CMS and South Carolina Healthy Connections Medicaid qualifying criteria.

VOLUNTARY DISENROLLMENT

A member may terminate their participation with ATC. Disenrollment from CICOs and enrollment from one CICO to a different CICO shall be allowed on a month-to month basis any time during the year; however, coverage will continue through the end of the month.

Note: It is very important to verify member's eligbility prior to rendering services.

MEMBER RIGHTS AND RESPONSIBILITIES

Members are informed of their rights and responsibilities through the Member Handbook. ATC providers are also expected to respect and honor member's rights and to post the Members Rights and Responsibilities in their offices.

ATC members have certain right and protections designed to:

- Protect you when you get health care
- Make sure you get the health care services that the law says you can get
- Protect you against unethical practices
- Protect your privacy
- Be treated with dignity and respect at all times
- Be protected from discrimination. Every company or agency that works with Medicare must obey the law, and can't treat you differently because of your race, color, national origin, disability, age, religion, or sex
- Have your personal and health information kept private
- Get information in a way you understand from Medicare, health care providers, and, under certain circumstances, contractors
- Get understandable information about Medicare to help you make health care decisions, including:
    - What's covered
    - What Medicare pays
    - How much you have to pay
    - What to do if you want to file a complaint or appeal
- Have your questions about Medicare answered
- Have access to doctors, specialists, and hospitals
- Learn about your treatment choices in clear language that you can understand, and participate in treatment decisions
- Get health care services in a language you understand and in a culturally-sensitive way
- Get emergency care when and where you need it
- Get a decision about health care payment, coverage of services, or prescription drug coverage
    - When a claim is filed, you get a notice from Medicare, South Carolina Healthy Connections Medicaid or ATC letting you know what it will and won't cover.
    - If you disagree with the decision of your claim, you have the right to file an appeal.
- Request a review (appeal) of certain decisions about health care payment, coverage of services, or prescription drug coverage.
    - If you disagree with a decision about your claims or services, you have the right to appeal.
- File complaints (sometimes called "grievances"), including complaints about the quality of your care

MEMBER PRESCRIPTION DRUG PLAN RIGHTS

A member has the following rights related to the Presciption Drug coverage.

- To request a coverage determination or appeal to resolve differences with the plan.
- To file a complaint (called a "grievance") with the plan.
- To have the privacy of health and prescription drug information protected.
    - Medications
    - Other Needs that form the basis of Our Integrated, Holistic Care Plan

Member engagement is critical to our Model – please help us:

- Explain benefits, provide health education, including how to access care (ex. appropriate Emergency Room utilization)
- Participate in community events and establish partnerships with local community agencies, churches, and high volume provider offices to promote healthy living and preventive care
- Identify and engage high-risk consumers
- Facilitate communication across medical, behavioral health, and long-term service and support specialties

Our approach with our Model of Care has been to:

- Focus on early identification
- Facilitate communication and coordination of services across medical and behavioral health specialties
- Identify and engage high-risk consumers
- Identify barriers to adherence with current treatment plans and goals
- Coordinate with consumer, their support system, and physicians to customize a plan of care
- Design a Care Coordination Team that has access to local community resources and supports such as shelter/housing, clothing, and utilities assistance

ATC strives to work with the provider community to ensure members' individual needs are met leveraging our care coordination approach. To reach our Medical Management Team for additional information on our MOC, please contact: 1-855-735-4398.

MEMBER APPEALS

An appeal is a request for review of an adverse action. An appeal may be requested by a member, member representative or their physician. Appeals can be initiated verbally, but before being acted on, ATC must receive written documentation that includes the reason for the appeal and the evidence that explains why the member needs the service. If a member representative or doctor is acting on behalf of the member, written consent is required.

Appeal information can be mailed or faxed. See contact information below.

If the service is again denied, the denial decision will have the written instructions regarding additional appeals rights such as requesting a State Fair Hearing and how the member may exercise their additional appeal rights.

Part C – Medical

- *Standard appeal*– pre-service, decision within 14 calendar days; post-service, within 30 calendar days
- *Expedited appeal*– 72 hours

Part D – Drug

- *Standard appeal*–decision within 7 calendar days
- *Expedited appeal*– 72 hours

Send Member Medicare Service (Part C) appeals to:
Absolute Total Care
Medicare Grievance & Appeals
7700 Forsyth Blvd
Clayton, MO 63105

Phone: 1-855-735-4398
Fax: 1-844 273 2671

Send Member Medicaid Service appeals to:
Absolute Total Care
Medicaid Grievance & Appeals
1441 Main Street, Suite 900
Columbia, SC 29201

Phone: 1-866-433-6041
Fax: 1-866-918-4457

Send Member Part D (Medication appeals) to:
Absolute Total Care
Medicare Grievance & Appeals
7700 Forsyth Blvd
Clayton, MO 63105

Phone: 1-855-735-4398
Fax: 1-844-273-2673

MEMBER COMPLAINTS

A complaint is a grievance or dispute, other than one that constitutes an organization determination (prior authorization determination), where the member is expressing dissatisfaction with the manner in which a health plan or delegated entity provides health care services.

A complaint may be requested by a member or the member's authorized representative within 60 days of the issue with the health plan or the provider.

A complaint is either called in, mailed or faxed. See below contact information. We will review the complaint and work with the member to identify a mutually beneficial outcome.

Standard complaint – Most complaints are answered in 5 business days. If we need more information and the delay is in the member's best interest, or if you ask for more time, we can take up to 14 more calendar days to answer a complaint.

Fast complaint – within 24 hours

Telephonic Grievances:
Call 1-855-735-4398 from 8 a.m. to 8 p.m., seven days a week. TTY users call 711.

Written Grievances:
Absolute Total Care
1441 Main Street, Suite 900
Columbia, SC 29201

Fax: 1-866-918-4457