arizona complete health
Complete Care Plan

Member *Handbook*

A helpful guide to getting services

Benefit Year 2019

Revised October 1, 2018

Arizona Complete Health-Complete Care Plan

Regional Behavioral Health Authority (RBHA)

Serving Members with a Serious Mental Illness (SMI) Designation, Comprehensive Medical and Dental Program (CMDP) and Division of Developmental Disabilities (DDD)

Covered services are funded under contract with AHCCCS.

Table of Contents

Helpful Information

ARIZONA COMPLETE HEALTH-COMPLETE CARE PLAN MEMBER SERVICES
1-888-788-4408 or TTY/TDY 711 we are available 24 hours a day, seven days a week, 365 days a year

CRISIS PHONE NUMBER
1-866-495-6735

MAILING ADDRESS
1870 W. Rio Salado Parkway
Tempe, AZ 85281

WEBSITE
azcompletehealth.com/completecare

Personal Information and Contact Information

My AHCCCS Member ID number

_____

	Name	**Phone Number**
My Primary Care Provider (PCP):		
Hospital:		
Pharmacy:		
Case Manager:		
My Psychiatrist or Nurse:		

HELP IN ANOTHER LANGUAGE AND FOR THE DISABLED: HOW CAN I GET HELP?
The Member Handbook and Provider Directory are provided at no cost to you. If you need this handbook, provider directory, or other health information in another language or in an

alternative format such as large font, audio or accessible pdf, please contact Member Services at 1-888-788-4408 or TTY/TDY 711. Or, visit us online at azcompletehealth.com/members/medicaid.html.

Also, if you need an interpreter please call Member Services at least five (5) days before your medical appointment to arrange the language assistance in time for your appointments. There is no cost for the interpretation. You are not required to use family or friends to interpret for you, and in fact, we discourage this from happening. Qualified interpreters should be used for any language assistance needs

Nondiscrimination and Accessibility

Discrimination is Against the Law

Arizona Complete Health-Complete Care Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Arizona Complete Health-Complete Care Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.
Arizona Complete Health-Complete Care Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters
- Provide 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 and information written in other languages

If you need these services, contact:
Arizona Complete Health-Complete Care Plan Member Services at 1-888-788-4408 (TTY: 711)

If you believe that Arizona Complete Health-Complete Care Plan failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Chief Compliance Officer, Cheyenne Ross. You can file a grievance in person, by mail, fax, or email. Your grievance must be in writing and must be submitted within 180 days of the date that the person filing the grievance becomes aware of what is believed to be discrimination. Submit your grievance to: Arizona Complete Health-Complete Care Plan Chief Compliance Officer-Cheyenne Ross, 1870 W. Rio Salado Parkway, Tempe, AZ 85281. Fax: 1-866.388.2247 Email: AzCHGrievanceAndAppeals@azcompletehealth.com

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 at U.S. Department of Health and Human Services; 200 Independence Avenue, SW; Room 509F,

HHH Building; Washington, D.C. 20201; or by phone: 1-800-368-1019, 1-800-537-7697 (TDD).

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

La discriminación es contra la ley

Arizona Complete Health-Complete Care Plan cumple con las leyes Federales de derechos civiles correspondientes y no discrimina con base en la raza, el color, la nacionalidad, la edad, la discapacidad o el sexo. Arizona Complete Health-Complete Care Plan no excluye a las personas ni las trata en forma distinta debido a su raza, color, nacionalidad, edad, discapacidad o sexo.
Arizona Complete Health-Complete Care Plan:

- Proporciona, sin cargo alguno, ayudas y servicios a las personas con discapacidades para que se comuniquen en forma eficaz con nosotros, como: intérpretes de lenguaje de señas calificados.
- Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles y otros formatos).
- Proporciona, sin cargo alguno, servicios de idiomas a las personas cuyo idioma primario no es el inglés, como: intérpretes calificados e información por escrito en otros idiomas.

Si necesita estos servicios, llame al Centro de Contacto con el Cliente al: 1- 888-788-4408 (TTY: 711)

Si considera que Arizona Complete Health-Complete Care Plan no ha proporcionado estos servicios o que ha discriminado de otra manera con base en la raza, el color, la nacionalidad, la edad, la discapacidad o el sexo, puede presentar una queja ante el Director General de Cumplimiento (Chief Compliance Officer), Cheyenne Ross. Puede presentar la queja en persona o por correo, fax, o correo electrónico. Su queja debe estar por escrito y debe presentarla en un plazo de 180 días a partir de la fecha en que la persona que presenta la queja se percate de lo que se cree que es discriminación.
Presente su queja a: Arizona Complete Health-Complete Care Plan, Chief Compliance Officer-Cheyenne Ross, 1870 W. Rio Salado Parkway Tempe, AZ 85281.
Fax: 1-866.388.2247 correo electrónico:
AzCHGrievanceAndAppeals@azcompletehealth.com

También puede presentar una queja de derechos civiles ante la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de Estados Unidos, electrónicamente mediante el Portal de Quejas de la Oficina de Derechos Civiles, disponible en https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, o por correo postal a U.S. Department of Health and Human Services; 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201; o por teléfono: 1-800-368-1019, 1-800-537-7697 (TDD).

Los formularios para presentar quejas se encuentran en http://www.hhs.gov/ocr/office/file/index.html.

arizona complete health

Attention: If you speak a language other than English, oral interpretation and written translation are available to you free of charge to understand the information provided. Call 1-888-788-4408 (TTY: 711).

Spanish	Si habla español, dispone sin cargo alguno de interpretación oral y traducción escrita. Llame al 1-888-788-4408 (TTY: 711).
Navajo	Diné k'ehjí yáníłti'go ata' hane' ná hóló dóó naaltsoos t'áá Diné k'ehjí bee bik'e'ashchįįgo nich'į' ádoolníiłgo bee haz'ą ałdó' áko díí t'áá át'é t'áá jíík'e kót'éego nich'į' ąą'át'é. Koji' hólne' 1-888-788-4408 (TTY: 711).
Chinese (Mandarin)	若您讲中文，我们会免费为您提供口译和笔译服务。 请致电 1-888-788-4408（TTY：711）。
Chinese (Cantonese)	我們為中文使用者免費提供口譯和筆譯。請致電 1-888-788-4408 (TTY: 711)。
Vietnamese	Nếu quý vị nói Tiếng Việt, có sẵn các dịch vụ thông dịch bằng lời và biên dịch văn bản miễn phí dành cho quý vị. Hãy gọi 1-888-788-4408 (TTY: 711).
Arabic	إذا كنت تتحدث اللغة العربية، تتوفر لك ترجمة شفهية وترجمة تحريرية مجانًا. اتصل بالرقم 1-888-788-4408 (TTY: 711).
Tagalog	Kung ikaw ay nagsasalita ng Tagalog, mayroong libreng oral na interpretasyon at nakasulat na pagsasalin na maaari mong gamitin. Tumawag sa 1-888-788-4408 (TTY: 711).
Korean	한국어를 하실 경우, 구두 통역 및 서면 번역 서비스를 무료로 제공해드릴 수 있습니다. 1-888-788-4408(TTY: 711)번으로 전화하십시오.
French	Si vous parlez français, vous disposez gratuitement d'une interprétation orale et d'une traduction écrite. Appelez le 1-888-788-4408 (TTY : 711).
German	Für alle, die Deutsch sprechen, stehen kostenlose Dolmetscher- und Übersetzungsservices zur Verfügung. Telefon: 1-888-788-4408 (TTY: 711).
Russian	Если вы говорите по-русски, услуги устного и письменного перевода предоставляются вам бесплатно. Звоните по телефону 1-888-788-4408 (TTY: 711).
Japanese	日本語を話される方は、通訳（口頭）および翻訳（筆記）を無料でご利用いただけます。 電話番号 1-888-788-4408（TTY : 711）。
Persian (Farsi)	اگر به زبان فارسی صحبت میکنید, ترجمه شفاهی و کتبی بدون هزینه برای شما قابل دسترسی میباشد. با شماره 1-888-788-4408 (TTY: 711) تماس بگیرید.
Syriac	[illegible] 1-888-788-4408 (TTY: 711).
Serbo-Croatian	Ako govorite srpsko hrvatski, usmeno i pismeno prevođenje vam je dostupno besplatno. Nazovite 1-888-788-4408 (TTY: 711).
Thai	หากคุณพูดภาษา ไทย เรามีบริการล่ามและแปลเอกสาร โดยไม่มีค่าใช้จ่าย โทรศัพท์ 1-888-788-4408 (TTY: 711)

Welcome to Arizona Complete Health-Complete Care Plan

Welcome to Arizona Complete Health-Complete Care Plan your Arizona Regional Behavioral Health Authority Complete Care Plan. Thank you for placing your trust in us. We look forward to serving you.

In this handbook, we use “you” and “your” to mean “the AHCCCS member.” We use “we,” “us,” “our” and “our plan” to mean “Arizona Complete Health-Complete Care Plan.” Only the member can get the benefits talked about in this handbook. Covered services are funded under contract with Arizona Health Care Cost Containment System (AHCCCS).

Arizona Complete Health-Complete Care Plan Member Services
Our Member Services Department (Member Services) is staffed by representatives who speak several languages, including English and Spanish. Member Services also uses a telephone interpreter service for members who speak a language that is not available within the department. You can call Member Services at 1-888-788-4408, TTY/TDY 711. If you speak another language other than English or Spanish, call Member Services and we will help get an interpreter to assist with the phone call.

When calling Member Services, please have the following information ready:

- Your name, your AHCCCS ID number, your date of birth, the phone number and address on file.
- You will also need a pen and paper to write down important information we will give you.

Some of the ways Member Services can help you:

- Answer questions about your covered services, benefits, and co-pays
- Provide information about doctors, nurse practitioners, and physician assistants
- Provide information about programs available to members
- Help you choose or change your PCP
- Help you schedule a ride to your doctor or medical appointments
- Help you make, change or cancel your medical appointments
- Provide you with dentist or specialist information
- Help you if you have a complaint or problem
- Help you with your rights as a member

- Help you schedule a language interpreter for your medical appointments if you cannot communicate with your doctor. **This service is provided at no cost to you**.
- Help you change your phone number and address with AHCCCS.
- If you are currently being treated for conditions such as diabetes, cancer, asthma, behavioral health, HIV/AIDS, or any disability, call Member Services immediately. We will refer you to an Integrated Care Manager to make sure you are getting the care you need.

CARE MANAGEMENT/CARE COORDINATION

Care Management and Care Coordination are a benefit we offer to Medicaid Enrolled members at no cost to you. Our goal is to help you be healthy through education and your own health care planning. Our nurses, behavioral health professionals and care coordinators will help you and/or a family member get the care you need, understand your medicines, help you obtain names and numbers for community resources, and work with you and your PCP and /or Health Home to get any other services you need to keep you healthy. If you want a Care Manager, please call Member Services at 1-888-788-4408 (TTY/TDD: 711) for a referral. Your PCP and/or Behavioral Health Home can refer you to Care Management/Care Coordination as well.

If you would like to learn more about the information in this Member Handbook, please call Arizona Complete Health-Complete Care Plan Member Services at: 1-888-788-4408, TTY/TDY 711 or visit our website at azcompletehealth.com/completecare

Nurse Advice Line

Arizona Complete Health-Complete Care Plan has a Nurse Advice Line available 24 hours a day, 7 days a week for members. You can call anytime to get assistance from a nurse or if you have questions about your health.

To speak to a nurse, please call: 1-866-534-5963

For life threatening emergencies always call **911**. Prior Authorization is not required for emergency services.

Emergency Care/ Urgent Care (After-Hours Care)

For life threatening emergencies always call **911**. Prior Authorization is not required for emergency services.

Should I go to the Emergency Room or Urgent Care?

Examples of **Emergency Room Symptoms**:

- Extreme Shortness of Breath
- Fainting
- Poisoning
- Chest Pains
- Uncontrolled Bleeding
- Seizures

Examples of **Urgent Care Symptoms**:

- Vomiting for more than 6 hours (if young child, call PCP)
- Diarrhea for more than 6 hours (if young child, call PCP)
- Sprained ankle
- Minor burns and rashes
- A minor allergic reaction
- Flu, sore throat with fever, earaches

After-Hours Care (Urgent Care)
An Urgent Care Center is a great place to get help because they usually have extended hours (after hours), doctors to treat common problems, and can see you quickly (usually in less than an hour). Urgent Care centers can help you with ear infections, sore throats, urinary tract infections, minor cuts and burns, sprains, and other common health issues. Urgent Care can be used for problems your doctor would normally help with. Member Services can help you find an Urgent Care center near you.

Emergency Room
Emergency rooms are for the treatment of emergency medical conditions, such as broken bones, severe pain, possible medicine overdose or poisoning, unconsciousness, excessive bleeding, seizures, chest pains or difficulty breathing.

If you need to see a doctor right away, contact your doctor for advice or to make an appointment. If your doctor is unable to see you, or the office is not open, please consider going to the closest Urgent Care center. Member Services can help you find an Urgent Care center near you.

How to access Behavioral Health Crisis Services

If you are experiencing a behavioral health crisis, call the Envolve People Care Crisis Line 1-866-495-6735, (TTY/TDY 711).

The Crisis Line offers immediate and confidential help 24 hours a day, 7 days a week, 365 days a year to anyone experiencing a behavioral health crisis, regardless of insurance coverage.

CRISIS SERVICES AVAILABLE TO YOU

You are able to get crisis services, even if you are not Title 19/21 eligible (i.e., not eligible for AHCCCS/not on Medicaid) or determined to have a Serious Mental Illness. Crisis services available to you include:

- Crisis Intervention phone services, including a toll free number, available 24 hours per day, 7 days a week
- Mobile Crisis Intervention services, available 24 hours per day, 7 days a week;
- 23-hour crisis observation/stabilization services, including detoxification services, and as funding allows, up to 72 hours of additional crisis stabilization; and
- Substance abuse-related crisis services, including follow-up services for stabilization.

How to Access Emergency Services While Out of the Service Area

You may need emergency services while you are away from home and out of the Arizona Complete Health-Complete Care Plan service area. This is called “out of area care.” Arizona Complete Health-Complete Care Plan. You have a right to use any hospital or other setting for emergency care. If you need out of area emergency care:

- Go to a hospital or crisis center and ask for help;
- Ask the hospital or crisis center to call 1-888-788-4408, TTY/TDY 711.
- The hospital or crisis center will contact Arizona Complete Health-Complete Care Plan for approval to services.

If you experience an emergency, emergency services are available to you at any hospital or other emergency room facility (in or out of network). Emergency services do not require prior authorization.

You can choose any hospital or other setting for emergency care. However, there are certain emergency settings within the Arizona Complete Health-Complete Care Plan network that may be easier for you to use.

Ensuring Culturally Competent Care

We value you. We understand that there are many diverse cultural and ethnic backgrounds of people in Arizona. We know that your health is affected by your beliefs, culture, and values.

We want to help you keep and maintain good health and good relationships with doctors and other providers who understand your needs. If you feel that there is a problem, please contact us. We will help you find a provider who will better understand your personal needs. We provide language assistance, including Sign Language interpreters, at no cost to you. We can also help you find a provider that speaks your language. If you cannot communicate with your provider because of a language barrier, we can schedule an interpreter to help with your appointment; please contact Member Services at 1-888-788-4408, (TTY/TDY 711).

Call us and let us know if we have overlooked anything that is important to you. We want to help. We want you to be comfortable with our services. If you would like to share cultural information that you feel is important to your health care, or select a provider based on convenience, location, disability accommodations, or cultural preference, please call Member Services at 1-888-788-4408, (TTY/TDY 711).

If you need any written member materials translated, or materials in alternate formats including large print, please call Member Services, we can provide those to you.

PRINTED INFORMATION FOR MEMBERS

If you need any written member materials translated, or materials in alternate formats including large print or Braille, please contact your provider or Arizona Complete Health-Complete Care Plan Member Services at 1-888-788-4408 or TTY/TDY: 711 or visit our website azcompletehealth.com/completecare to receive your materials in an alternative format

INTERPRETATION SERVICES

We provide language assistance, including Sign Language interpreters, at no cost to you. We can also help you find a provider that speaks your language. If you cannot communicate with your provider because of a language barrier, we can schedule an interpreter to help with your appointment; please contact Member Services at 1-888-788-4408, (TTY/TDY 711).

SIGN LANGUAGE INTERPRETERS AND AUXILIARY AIDS

If you are deaf or hard of hearing, you may ask that your provider provide auxiliary aids or schedule a Sign Language Interpreter to meet your needs. Your provider has to provide these services to you.

Auxiliary aids include computer-aided transcriptions, written materials, assistive listening devices, or systems, closed and open captioning, and other effective methods of making aurally delivered materials available to individuals with hearing loss.

Sign Language Interpreters are skilled professionals certified to provide interpretation, usually in American Sign Language, to the deaf. To find a listing of sign language interpreters and for the laws regarding the profession of interpreters in the State of Arizona, please visit the Arizona Commission for the Deaf and the Hard of Hearing at www.acdhh.org or call (602) 542-3323 (V); (602) 364-0990 (TTY); 800-352-8161 (V/TTY); (480) 559-9441 (Video Phone).

WHAT LANGUAGES DO PROVIDERS SPEAK?

A listing of all available providers, their locations, telephone numbers, and languages spoken can be found online at azcompletehealth.com/completecare If you would like to select a provider based on convenience, location, disability accommodations, or cultural preference, please call Arizona Complete Health-Complete Care Plan Member Services.

ASSISTANCE IN ANOTHER LANGUAGE AND FOR INDIVIDUALS WITH DISABILITIES: HOW CAN I GET HELP?

If you have a physical disability, network provider offices should accommodate you. You can call Member Services to find a provider who can meet your needs at 1-888-788-4408 (TDY/TDD: 711), or search for a provider online with our Find a Provider tool at azcompletehealth.com/completecare

OUR MEMBER SERVICES IS HERE TO HELP

Arizona Complete Health-Complete Care Plan will help you choose a provider from within the provider network. If you would like to select a provider based on convenience, location, disability accommodations, or cultural preference, please call Arizona Complete Health-Complete Care Plan Member Services. You will need to contact the provider to make, change, or cancel your appointments. You may also contact Arizona Complete Health-Complete Care Plan if you would like assistance with making, changing, or canceling your appointments.

If you are not happy with your current provider, contact Arizona Complete Health-Complete Care Plan Member Services to discuss other available options.

If you do not have access to the Internet at your home, no cost Internet service is usually available at libraries. You can also get a paper copy of the Provider Directory at no charge by

calling Arizona Complete Health-Complete Care Plan at 1-888-788-4408 or TTY/TDY 711 or by visiting our website azcompletehealth.com/completecare

If you visit a provider not in our network

You are required to access services through Arizona Complete Health-Complete Care Plan contracted network providers. You can find an Arizona Complete Health-Complete Care Plan contracted provider by visiting our website at azcompletehealth.com/completecare and click on the Find a Provider link or you can call our Member Services Line for assistance. If you visit a provider not in our network, the provider will likely not be paid for the services you receive and you may be billed for the services by the provider. Exceptions to this requirement include Emergency Services and out-of-network single-case agreements approved and authorized by Arizona Complete Health-Complete Care Plan Utilization Management department. You may receive emergency services from the nearest emergency center, whether that Center is contracted with Arizona Complete Health-Complete Care Plan or not. This includes out-of-state Emergency Centers when traveling out-of-state. If you do not find a provider contracted with Arizona Complete Health-Complete Care Plan that can meet your treatment needs, please call Member Services for assistance. If Arizona Complete Health-Complete Care Plan is unable to locate an in-network provider to meet your treatment needs, our team will enter into a special agreement with an out-of-network provider for you.

How to get a printed provider directory

The Arizona Complete Health-Complete Care Plan provider directory is available at no cost to you. For a copy, please call Member Services at 1-888-788-4408 TTY/TDY 711 or you can view a printable copy on our website: azcompletehealth.com/completecare

Where we serve

Arizona Complete Health-Complete Care Plan Regional Behavioral Health Authority serves members in the following counties: Cochise, Graham, Greenlee, La Paz, Pima, Pinal, Santa Cruz and Yuma including the San Carlos Tribal area.

Arizona Complete Health-Complete Care Plan is a Managed Care Plan. A Managed Care Plan is a health plan that provides care to its members through a select group of doctors, hospitals, and pharmacies. You and your Primary Care Physician (PCP) play an important role in your managed care plan. Your PCP is the coordinator of your care and helps decide what services you need. It

is your rresponsibility to see your PCP and/or your Behavioral Health Home and talk with them about your health.

Contact the Arizona Complete Health-Complete Care Plan Member Services with any questions or concerns about your health benefits or medical services.

YOUR MEMBER ID CARD

If you have an Arizona driver's license or state issued ID, AHCCCS will obtain your picture from the Arizona Department of Transportation Motor Vehicle Division (MVD). The AHCCCS eligibility verification screen that providers see contains your picture (if available) and details on your coverage.

Only you are allowed to use your Arizona Complete Health-Complete Care Plan ID card for services. Never lend, sell, or allow someone to use your card. This is against the law, and you might lose your AHCCCS eligibility. Legal action may also be taken against you.

It is your responsibility to protect your ID card. **Remember**: any misuse of the card, including loaning, selling or giving it to others could result in loss of your eligibility and/or legal action. **It is very important that you keep your ID card in a safe place and do not throw it away.**

Member Responsibilities

As an Arizona Complete Health-Complete Care Plan member, you can contribute to your health. As a member you have the responsibility to:

- Provide, to the extent possible, information needed by professional staff to care for you
- Follow instructions and guidelines given by those providing health care
- Know the name of your assigned PCP (Primary Care Provider)
- Schedule appointments during office hours whenever possible instead of using urgent care facilities or emergency rooms
- Arrive for appointments on time
- Notify the provider in advance when it is not possible to keep an appointment
- Bring immunization records to every appointment for children ages 18 and younger
- Share Information
    - If you do not understand your health condition or treatment plan, ask your doctor to explain
    - Give your doctors, providers and care manager all the facts about your health problems, past illnesses, hospital stays, all medications, shots and other health concerns.

- Participate in Recovery
  - Know the name of your doctors and/or your care manager
  - Participate in creating your Service Plan
  - Follow the instructions that you and your doctors have agreed on, including the instructions of nurses and other health care professionals

WHAT TO DO WHEN YOUR FAMILY SIZE CHANGES OR YOUR MEMBER INFORMATION CHANGES

You must call the office that made you eligible for AHCCCS to add a new member or if any family member leaves and your family becomes smaller.

- DES www.healthearizonaplus.gov or 1(855)HEA-PLUS (1-855-432-7587)
- KidsCare www.healthearizonaplus.gov or 1(855)HEA-PLUS (1-855-432-7587)
- SSI MAO www.healthearizonaplus.gov or 602-417-5010/1-800-528-0142 Outside Maricopa County
- Social Security Administration (1-800-772-1213)
- ALTCS Local Offices

Please remember it is important to report a new baby immediately after the birth so that your baby will be eligible for services.

If any of your information changes, such as your phone number or address, please call Member Services at 1-888-788-4408 so we can assist you with making those changes.

If you have any questions, call Arizona Complete Health-Complete Care Plan Member Services.

IF YOU MOVE, YOU MUST TELL US!

As a member of our plan, your service area is southern and central Arizona. If you move out of the United States, the state of Arizona, or out of southern or central Arizona, your current plan will no longer be valid. Before you move, call Member Services to update your address. We can often update your address with the AHCCCS eligibility office.

You could lose your care with AHCCCS if you do not tell them you are moving.

Other places you should notify include:

- Your PCP
- The Supplemental Security Income (SSI) office, if you are receiving SSI benefits
- Department of Economic Security (DES), if you receive TANF, food stamps
- For KidsCare (Title XXI) members, please call AHCCCS at 1-602-417-5437 or the toll-free statewide number, 1-877-764-5437.

Call Arizona Complete Health-Complete Care Plan Member Services if you have questions about your enrollment or call AHCCCS at 1-800-654-8713 or 1-602-417-4000.

Family Voice & Decision Making

Our healthcare providers are expected to include responsible family members and other authorized individuals as decision-makers in the treatment planning process. It is important that responsible family members and other authorized individuals attend as many discussions as possible regarding treatment planning for the member. That way, as the decision-maker, you will be able to make the most informed decisions regarding health care for the member. If you feel your voice is not being heard please contact our Advocacy Team for help by calling Member Services at 1-888-788-4408 or TTY/TDY 711.

Transition of Care Policy

We want to help you if you are moving and you have a new AHCCCS plan. We can help transition your care to your new health plan and providers.

Arizona Complete Health-Complete Care Plan will always help with coordination of care for all of our members during the following types of transitions: Managed Care Organizations, changes in service areas, health care providers or from Fee for Service to Managed Care Organization. Certain members may require additional help during a period of transition. If you have questions about coordination of care when making changes, please call Member Services at 1-888-788-4408 or TTY/TDY 711.

Arizona Complete Health-Complete Care Plan shall receive information from your past health plan or will contact your new health plan to assist with coordination of your care to ensure your care will continue without disruption. If you have concerns regarding a potential transition of your care, please contact Member Services at 1-888-788-4408 or TTY/TDY 711.

How do I use the emergency room appropriately?

If your life is in immediate danger, call 911. If you need to see a doctor right away, contact your PCP for advice or to make an appointment. If your doctor is unable to see you, or the office is not open, please consider going to the closest Urgent Care center. Member Services can help you find an Urgent Care center near you.

Should I go to the Emergency Room or Urgent Care?

Examples of **Emergency Room Symptoms**:

- Extreme Shortness of Breath
- Fainting
- Poisoning
- Chest Pains
- Uncontrolled Bleeding
- Seizures

Examples of **Urgent Care Symptoms**:

- Vomiting for more than 6 hours (if young child, call PCP)
- Diarrhea for more than 6 hours (if young child, call PCP)
- Sprained ankle
- Minor burns and rashes
- A minor allergic reaction
- Flu, sore throat with fever, earaches

WHAT TO DO IN CASE OF AN EMERGENCY

Medical emergencies are sudden conditions, which are life or death situations. They may lead to disability or death if not treated as soon as possible. **No Prior Authorization is necessary for emergency care.**

If you feel your symptom is an emergency, call 911 or go to the nearest Emergency Department. As a member of our plan, you have the right to seek Emergency Service at any hospital or other Emergency Room facility (in or out of network). Please tell the Emergency Department staff that you are a Arizona Complete Health-Complete Care Plan member and show your ID card. If you are unable to do this, have a family member or friend tell the Emergency Department staff that you are a member of our plan.

What if you need Emergency Care out of our service area?

Our plan will pay for emergency care while you are out of the county or state. If you need emergency care, show your Arizona Complete Health-Complete Care Plan ID card so the doctors can notify us.

Transportation: How Do I Get Rides to Medical Appointments?

EMERGENCY TRANSPORTATION

Your condition is a medical emergency when your life, body parts or bodily functions are at risk of damage or loss unless immediate care is received. Emergency transportation is a covered benefit.

In cases of emergency (in a life-threatening situation) call 911.

Some examples of **Emergency Symptoms** include extreme Shortness of Breath, fainting, poisoning, chest pains, uncontrolled bleeding, and seizures.

Prior Authorization is not required for emergency services, including emergency transportation.

In crisis situations Arizona Complete Health-Complete Care Plan has resources available for transportation. Please call our Crisis Line at: 1-866-495-6735.

NON-EMERGENCY TRANSPORTATION

Members can get rides to doctor appointments in several ways. The easiest way is to find a ride with a family member or a friend. If family is unavailable, and you have a Behavioral Health Home, your Behavioral Health Home is required to assist you with transportation. If you don't have a Behavioral Health Home or your Behavioral Health Home is unable to meet your transportation needs, please contact Member Services. We will arrange for transportation for medical appointments. Please contact us three (3) days before the appointment.

You can call Member Services on weekends and holidays, for transportation to urgent care centers when you are sick.

Always remember to dial 911 in a true medical emergency.

If you call to get a ride to a medical appointment, please be ready to tell the representative the following:

- Your name, AHCCCS ID number, date of birth, address, phone number (for verification purposes).
- The date, time and address of your medical visit.
- If you need a ride one way or a round trip.
- Your travel needs (wheelchair, stretcher or other).
- Any special needs (oxygen, IVs, someone who needs to travel with you, an extra-wide or

electric wheelchair, a high-top vehicle, etc.).

- Children under the age of 5 require a car seat. Children ages 5 through 7 and shorter than 4'9" require a booster. You must provide a car seat for your child for the trip.

WHEELCHAIR OR STRETCHER

If you need a wheelchair or a stretcher for your ride to a routine doctor's visit, patient transport services vans can take you there and bring you back. You must call Member Services to set up these rides at least three (3) to four (4) working days before your appointment date.

CANCELING RIDES TO YOUR APPOINTMENTS

If you cancel your doctor or dentist visit, you must also call Member Services to cancel your ride to your visit. Please call us at 1-888-788-4408 or TTY/TDY 711.

What is Covered: What Kind of Health Care Can I Get from Arizona Complete Health-Complete Care Plan (AzCH-CCP)?

In order for you to get health care service through our Plan, the service must be both:

- A Covered Benefit based on your coverage with AHCCCS, and
- Medically Necessary.

A "Covered Benefit" means that you can get this service through AHCCCS and Arizona Complete Health-Complete Care Plan. "Medically Necessary" means that a covered service is provided by a physician or other licensed practitioner of the healing arts within the scope of practice under state law to prevent disease, disability or other adverse health conditions or their progression, or prolong life.

Arizona Complete Health-Complete Care Plan covers members from many groups. Please see below to see what services are covered for you.

MEMBERS ENROLLED IN THE COMPREHENSIVE MEDICAL AND DENTAL PROGRAM (CMDP) AND MEMBERS ENROLLED IN THE DEPARTMENT OF ECONOMIC SECURITY/DIVISION OF DEVELOPMENTAL DISABILITIES (DDD)

If you are enrolled with the AHCCCS Comprehensive Medical and Dental Program (CMDP) or the Arizona Department of Economic Security/Division of Developmental Disabilities (DDD) and are also enrolled with Arizona Complete Health-Complete Care Plan, you are eligible for the full array of AHCCCS Behavioral Health Services listed below through our Plan. Your physical health services will continue to be provided through your affiliated health plan. Arizona Complete Health-Complete Care Plan will actively coordinate services with your health plan on your behalf.

MEMBERS WHO HAVE BEEN DESIGNATED AS SERIOUSLY MENTALLY ILL (SMI) AND ARE ENROLLED IN MEDICAID

If you are a Medicaid enrolled adult and enrolled in the Arizona Complete Health-Complete Care Plan that has been designated as Seriously Mentally Ill and are not dually enrolled in CMDP or DDD as described above, you are eligible to receive both your physical health and behavioral health care through Arizona Complete Health.

MEDICAID/MEDICARE DUAL ELIGIBLE MEMBERS

If you are a "dual eligible" member (Medicare and Medicaid enrolled), it often means that you have additional benefits that may not be covered under AHCCCS. When we know about your other insurance, it helps us coordinate the care you receive with the other plan. If you have Medicare coverage and you see a doctor that is not on our plan, the charges may not be covered. If you choose to do that without our approval, we may not pay for those services because they were done by a doctor that is not on our plan. It is important that you work with your PCP and/or Health Home to be referred to the right doctors. (This requirement does not include emergency services. You do not need approval to receive emergency services.) We will not cover copays or deductibles for services provided outside of the Arizona Complete Health-Complete Care Plan contracted Network without Prior Authorization.

ADULTS WITH SMI NOT ENROLLED IN MEDICAID

If you are enrolled with Arizona Complete Health-Complete Care Plan as a Non-Medicaid Adult designated with Serious Mental Illness (SMI), you are eligible for a limited behavioral health benefit only (reference the table of behavioral health benefits for details).

GRANT FUNDED PROGRAMS FOR UNINSURED AND UNDERINSURED ARIZONA CITIZENS

If you live in Cochise, Graham, Greenlee, La Paz, Pima, Pinal, Santa Cruz, or Yuma Counties, and are experiencing a Substance Use Disorder (SUD) or Opioid Use Disorder (OUD), you very well may be eligible for SUD treatment services through Arizona Complete Health-Complete Care Plan. Call our Member Services for more information and clarification about coverage.

Care Management/Care Coordination

Care Management and Care Coordination are a benefit we offer to Medicaid Enrolled members at no cost to you. Our goal is to help you be healthy through education and your own health care planning. Our nurses, behavioral health professionals and care coordinators will help you and/or a family member get the care you need, understand your medicines, help you obtain names and numbers for community resources, and work with you and your PCP and /or Health Home to get any other services you need to keep you healthy. If you want a Care Manager, please call Member Services at 1-888-788-4408 (TTY/TDD: 711) for a referral. Your PCP and/or Behavioral Health Home can refer you to Care Management/Care Coordination as well.

Medicaid Covered Physical Health Services

The following services are available to Medicaid enrolled members that are not CMDP enrolled or DDD enrolled. See the boxes below for details if you belong to either of these categories or if you are not enrolled. Call Member Services or talk to your PCP and/or Health Home for more information about these services.

PHYSICAL HEALTH SERVICES FOR MEMBERS THAT ARE CMDP OR DDD ENROLLED

Members that are CMDP enrolled or DDD enrolled are only eligible to receive behavioral health services through Arizona Complete Health-Complete Care Plan Regional Behavioral Health Authority (RBHA). Members enrolled in CMDP and/or DDD receive physical health services through their associated health plan.

- Ambulance for emergency care
- Audiology services to evaluate hearing loss on both outpatient and inpatient basis
- Care while you are pregnant
- Case management
- Checkups for children*, pregnant individuals, and Qualified Medicare Beneficiary (QMB)
- Children's services including routine dental care
- Chiropractic services are covered services for adults over the age of 21, and Qualified Medicare Beneficiary (QMB) Dual members.
- Emergency medical and surgical services related to dental (oral) care
- Adult emergency dental benefits up to $1,000
- Dialysis
- Disease Management
- Emergency or Urgent Care medical treatment
- Eyeglasses or contacts for children, or adults only after cataracts are removed
- Family planning / birth control
- Foot and ankle care services for adults, including wound care, treatment of pressure ulcers, fracture care, reconstructive surgeries, and limited bunionectomy services.
- Health care services including screenings, diagnosis and medically necessary treatments

- Home and Community Based Services (HCBS)
- Hospital care
  - Blood and blood plasma
  - Intensive care
  - Laboratory, x-ray and imaging services
  - Medicines
  - Nursing care
  - Operating room and hospital care
  - Services of doctors, surgeons, specialists
- Occupational and Speech Therapy is covered for all members receiving inpatient hospital (or nursing facility services). Outpatient occupational therapy and outpatient speech therapy is only covered for members under age 21.
- Outpatient physical therapy to restore a level of function is limited to 30 visits per contract year for members 21 years of age and older and unlimited for members under age 21.
- Insulin Pumps
- Lab work and x-rays
- Medical foods for members diagnosed with one of the following inherited metabolic conditions:
  - Phenylktonuria
  - Homocystinuria
  - Maple Syrup Urine Disease
  - Galactosemia (requires soy formula)
  - Beta Keto-Thiolase Deficiency
  - Citrullinemia
  - Glutaric Acidemia Type I
  - 3 Methylcrotonyl CoA Carboxylase Deficiency
  - Isovaleric Acidemia
  - Methylmalonic Acidemia
  - Propionic Acidemia
  - Arginosuccinic Acidemia
  - Tyrosinemia Type I
  - HMG CoA Lyase Deficiency
  - Cobalamin A, B, C Deficiencies
- Medical tests
- Medically needed podiatry services. AHCCCS covers medically necessary podiatry services that are performed by a licensed podiatrist and ordered by a primary care provider or primary care practitioner.
- Medicine from the approved Arizona Complete Health-Complete Care Plan Drug List (Drug List)
- Nursing facility
- PCP office visits for children*, QMB, or when an adult has a symptom or sickness
- Pregnancy termination (including Mifepristone [Mifeprex or RU-486])
- Post stabilization services
- Respiratory therapy
- Rides to health care visits
- Supplies and equipment, including Drug List diabetic testing equipment and supplies
- Well-child checkups including dental, hearing, shots and vision care*

DISEASE MANAGEMENT

Disease Management is a service offered at no cost to members who are receiving their health care through our integrated plan. If you have a health problem such as anxiety, chronic pain, diabetes, asthma, Chronic Obstructive Pulmonary Disease (COPD), heart failure or coronary artery disease, our Disease Managers are here to help you. Please call Member Services if you want to be referred for disease management assistance or for more information. If you are enrolled in DDD or CMDP, you can call your physical health plan for more information about managing your health.

ORTHOTICS CARE

Orthotic devices for members under the age of 21 are provided when prescribed by the member's Primary Care Provider, attending physician, or practitioner.

Arizona Complete Health-Complete Care Plan covers orthotic devices for **members who are 21 years of age and older** when:

- The orthotic is medically necessary as the preferred treatment based on Medicare Guidelines AND
- The orthotic costs less than all other treatments and surgery procedures to treat the same condition AND
- The orthotic is ordered by a Physician (doctor) or Primary Care Practitioner (nurse practitioner or physician assistant).

If you have any questions, please call Member Services at 1-888-788-4408 or TTY/TDD: 711.

Medical equipment may be rented or purchased only if other sources, which provide the items at no cost, are not available. The total cost of the rental must not exceed the purchase price of the item. Reasonable repairs or adjustments of purchased equipment are covered for all members over and under the age of 21 to make the equipment serviceable and/or when the repair cost is less than renting or purchasing another unit. The component will be replaced if at the time authorization is sought documentation is provided to establish that the component is not operating effectively.

Additional Medical Covered Services for Adults with an SMI designation Ages 18 to 21

Additional Covered Services for Adult Members with an SMI designation ages 18 to 21
• Identification, evaluation and rehabilitation of hearing loss • Medically necessary personal care. This may include help with bathing, toileting, dressing, walking and other activities that the member is unable to do for medical reasons • Routine preventive dental services, including oral health screenings, cleanings, oral hygiene education, X-rays, fillings, extractions and other therapeutic and medically necessary procedures • Vision services, including exams and prescriptive lenses (a limited selection of lenses and frames are covered) • Outpatient speech, occupational and physical therapy • Conscious sedation • Children's Rehabilitation Services (CRS) (Limitations apply.) • Additional Services for Qualified Medicare Beneficiaries (QMB) • Respite services • Chiropractic services • Any services covered by Medicare but not by AHCCCS.

Table of Behavioral Health Covered Services

Available Behavioral Health Services			
SERVICES		**All TITLE 19/21 CHILDREN AND ADULTS**	**NON-TITLE 19/21 PERSONS DETERMINED TO HAVE SMI**
TREATMENT SERVICES			
Behavioral Health Counseling and Therapy	Individual	Available	Provided based on available state and federal grant funding
	Group	Available	Provided based on available state and federal grant funding

	Family	Available	Provided based on available state and federal grant funding
Behavioral Health Screening, Mental Health Assessment and Specialized Testing	Behavioral Health Screening	Available	Provided based on available state and federal grant funding
	Mental Health Assessment	Available	Provided based on available state and federal grant funding
	Specialized Testing	Available	Provided based on available state funding
Other Professional	Traditional Healing	Provided based on available federal grant funding	Provided based on available federal grant funding
	Auricular Acupuncture	Provided based on available federal grant funding	Provided based on available federal grant funding
	Intensive Outpatient	Available	Provided based on available state and federal grant funding (only SUD services)
	Multisystemic Therapy for Juveniles	Available	Not Available
REHABILITATION SERVICES			
Skills Training and Development; Psychosocial Rehabilitation	Individual	Available	Provided based on available state and federal grant funding
	Group	Available	Provided based on available state and federal grant funding
Cognitive Rehabilitation		Available	Provided based on available state and federal grant funding

Behavioral Health Prevention/Promotion Education	Available	Provided based on available state and federal grant funding
Psycho Educational Services and Ongoing Support to Maintain Employment	Available	Provided based on available state and federal grant funding
BEHAVIORAL HEALTH MEDICAL SERVICES		
Behavioral Health Medication Services	Available	Medication Assisted Treatment provided based on available state and federal grant funding (grant fund limitations) See Behavioral Health Drug List for covered medication.
Behavioral Health Lab, Radiology, and Medical Imaging	Available	Medication Assisted Treatment Related Labs provided based on available state and federal grant funding (grant fund limitations)
Behavioral Health Related Medical Management	Available	Medication Assisted Treatment Related Labs provided based on available state and federal grant funding (grant fund limitations)
Electro-Convulsive Therapy	Available	Not Available
SUPPORT SERVICES		
Case Management	Available	Provided based on available state and federal grant funding

Personal Care	Available	Provided based on available state and federal grant funding
Home Care Training (Family)	Available	Provided based on available state and federal grant funding
Self-Help/Peer Services	Available	Provided based on available state and federal grant funding
Home Care Training to Home Care Client (HCTC)	Available	Not Available
Respite Care (Reference Limitations Section for details about coverage limits)	Available	Provided based on available state and federal grant funding
Supported Housing	Provided based on available state and federal grant funding	Provided based on available state and federal grant funding
Sign Language or Oral Interpretive Services	Provided at no charge to the member	Provided at no charge to the member
Emergency Behavioral Health Transportation	Available	Provided based on available state funding
Non-emergency Behavioral Health Transportation	Available	Limited to crisis service-related transportation
Crisis Intervention – Mobile Community Based	Available	Available
Crisis Intervention – Telephone	Available	Available
Crisis Services – up to 23 Hour Stabilization, Facility Based	Available	Available
INPATIENT SERVICES		

Behavioral Health Detox Inpatient Facility (Substance Use Disorders)	Available	Provided based on available federal grant funding
Behavioral Health Inpatient Facility (Mental Health Disorders)	Available	Three day limit per admission in Sub Acute Facilites only based on available state funding
RESIDENTIAL SERVICES		
Behavioral Health Residential Facility (Mental Health Treatment)	Available	Not Available
Behavioral Health Residential Facility (Substance Use Disorder Treatment)	Available	Provided based on available state and federal grant funding
Room and Board	Provided based on available state and federal grant funding	Provided based on available state and federal grant funding
BEHAVIORAL HEALTH DAY PROGRAMS		
Supervised Day Program	Available	Provided based on available state and federal grant funding
Therapeutic Day Program	Available	Provided based on available state and federal grant funding
Medical Day Program	Available	Provided based on available state and federal grant funding

Non-Covered Services: What does AHCCCS Not Cover?

- Non-emergency physical health services that are not prior approved by your PCP.
- Any care, treatment, or surgery that is not medically necessary.
- Infertility services that include testing and treatment.
- Reversals of elective sterilization.
- Gender affirming operations.
- Exams to establish the need for hearing aids, glasses, or contacts for members 21 years and older, except after cataract surgery.
- Hearing aids, eye glasses, or contacts for members 21 years and older, except after cataract surgery.
- Services or items for cosmetic reasons.
- Personal or comfort items (only covered for EPSDT, if medically indicated).
- Non-prescription drugs or supplies
- Services given in an institution for the treatment of tuberculosis (TB).
- Medical service given to an inmate or to a person in the custody of a state mental health institution.
- Outpatient speech and occupational therapy for members 21 years and older. (Please note: Speech therapy provided on an outpatient basis is covered only for members receiving EPSDT services, and KidsCare (Title 21) members.)
- Lower limb microprocessor controlled joint/prosthetic for members 21 years of age and older.
- Any service determined as experimental/investigational or done mainly for research or that has not been approved by regulating agencies. AHCCCS members who are enrolled with a plan may participate in experimental treatment, but AHCCCS will not reimburse for the experimental treatment.
- **Transplants including:** Pancreas only transplants (total, partial or islet cell); or any other transplant not listed by AHCCCS as covered.
- Physical exam for non-medical purposes (for example, job, school or insurance exams).
- Abortion counseling and abortions (unless medically necessary per AHCCCS medical policies).
- Any medical services outside of the country.
- Routine/newborn circumcisions.
- Routine health care (out-of-area).

Exclusions and Limitations Table

The following services are not covered or are limited services for <u>adults 21 years and older</u>. If you are a Qualified Medicare Beneficiary (QMB), we will continue to pay your Medicare deductible and coinsurance for these services.		
BENEFIT/SERVICE	SERVICE DESCRIPTION	SERVICE EXCLUDED FROM PAYMENT
Bone-Anchored Hearing Aid	A hearing aid that is put on a person's bone near the ear by surgery. This is to carry sound.	AHCCCS will not pay for the Bone-Anchored Hearing AID (BAHA). Supplies, equipment maintenance (care of the hearing aid) and repair of any parts will be paid for.
Cochlear Implant	A small device that is put in a person's ear by surgery to help you hear better.	AHCCCS will not pay for cochlear implants. Supplies, equipment maintenance (care of the implant) and repair of any parts will be paid for.
Lower limb Microprocessor controlled joint/ Prosthetic	A device that replaces a missing part of the body and uses a computer to help with the moving of the joint.	AHCCCS will not pay for a lower limb (leg, knee, or foot) prosthetic that includes a microprocessor (computer chip) that controls the joint.
Orthotics	A support or brace for weak joints or muscles. An orthotic can also support a deformed part of the body. Orthotics means items like leg braces, wrist splints and neck braces.	Arizona Complete Health-Complete Care Plan covers orthotic devices for **members who are 21 years of age and older** when: ➢ The orthotic is medically necessary as the preferred treatment based on Medicare Guidelines AND ➢ The orthotic costs less than all other treatments and surgery procedures to treat the same condition AND ➢ The orthotic is ordered by a Physician (doctor) or Primary Care Practitioner (nurse practitioner or physician assistant).

Respite Care	Short-term or continuous services provided as a temporary break for caregivers and members to take time for themselves.	The number of respite hours available to adults and children under ALTCS benefits or behavioral health services is being reduced from 720 hours to 600 hours within a 12 month period of time. The 12 months will run from October 1 to September 30 of the next year.
Services by Podiatrist	Any service that is done by a doctor who treats feet and ankle problems.	AHCCCS covers medically necessary podiatry services that are performed by a licensed podiatrist and ordered by a primary care provider or primary care practitioner.
Transplants	A transplant is when an organ or cells are moved from one person to another.	Approval is based on the medical need and if the transplant is on the "covered" list. Only transplants listed by AHCCCS as covered will be paid for.
Physical Therapy	Exercises taught or provided by a Physical Therapist to make you stronger or help improve movement.	Outpatient physical therapy visits to restore a level of function are limited to 30 visits per contract year (October 1 to September 30 of the following year). Members who have Medicare should talk to the health plan for help in determining how the visits will be counted.

Arizona Complete Health-Complete Care Plan will not be responsible for payment for any non-covered services you choose to receive. In special cases you may be able to get services outside of your service area. Please contact Member Services if you would like more information about this.

Consent to Treatment

You have the right to accept or refuse behavioral health services that are offered to you. If you want to get the behavioral health services offered, you or your legal guardian must sign a "Consent to Treatment" form giving your or your legal guardian's permission for you to get behavioral health services. When you sign a "Consent to Treatment" form, you are also giving the Arizona Health Care Cost Containment System (AHCCCS) permission to access your records.

To give you certain services, your provider needs to get your permission. Your provider may ask you to sign a form or to give verbal permission to get a specific service. You will be given information about the service so you can decide if you want that service or not. This is called informed consent. Informed consent means advising a patient of a proposed treatment, surgical procedure, psychotropic drug, or diagnostic procedure; alternatives to the treatment surgical procedure, psychotropic drug or diagnostic procedure; associated risks and possible complications, and obtaining documented authorization for the proposed treatment, surgical procedure, psychotropic drug, or diagnostic procedure from the patient or the patient's representative. An example would be if your provider prescribes a medication. Your provider will tell you about the benefits and risks of taking the medication and other options for treatment. Your provider will ask you to sign a consent form or give verbal permission if you want to take the medication. Let your provider know if you have questions or do not understand the information your provider gave you. You have the right to withdraw your consent at any time. Your provider will explain to you what will happen if you choose to withdraw your consent.

Grant Funded Services Available to Medicaid Enrolled and Uninsured or Underinsured Arizona Citizens

Medicaid enrolled, uninsured, and underinsured individuals may qualify to receive specific types of interventions, services, prevention, treatment and support through grant funding. There are many types of grants and all of them have detailed established guidelines that outline who is eligible to receive these funds. For example, grant funds might offers services for individuals who are not covered by AHCCCS, are uninsured and/or are under-insured. All grants have rules about the services a grant recipient can provide and who is eligible. Special populations include groups of individuals who are eligible to receive services funded by grants. Individuals should contact their health care provider, Behavioral Health Home and/or Arizona Complete Health-Complete Care Plan about qualifications and eligibility.

TYPES OF GRANTS

Federal Block Grants. These include the Substance Abuse Block Grant (SABG), Mental Health Block Grant (MHBG), and Project for Assistance in Transition from Homelessness (PATH) Grant.

1. The **SABG Block Grant** funds are used for treatment and long-term recovery support services for the following persons, in order of priority:

- Pregnant individuals/teenagers who use drugs by injection;
- Pregnant individuals/teenagers who use substances;
- Other persons who use drugs by injection;
- Substance using females with dependent children and their families, including females who are attempting to regain custody of their children; and
- As Funding is Available - all other individuals with a substance use disorder, regardless of gender or route of use.

2. The **Mental Health Block Grant (MHBG)** are used to establish or expand community-based services for Non-Title 19/21 reimbursable mental health services to children with Serious Emotional Disturbances (SED) and adults with Serious Mental Illness (SMI).

OTHER FEDERAL AND STATE GRANTS

Arizona Complete Health-Complete Care Plan also has grants that offer engagement, specific treatment services and support to targeted populations and are often time-limited. For example:

- Grants for certain diagnostic groups and health challenges;
- Opioid Use Disorder grants for uninsured and underinsured citizens;
- Grants for outreach and prevention activities;
- Grants that target the opioid epidemic;
- Grants to assist individuals with community reintegration (i.e. jails/prisons);
- Grants that are for training (for providers, schools, health plans and other organizations); and/or
- Short-term grants that have a singular purpose and end after a defined time-line and/or activity completion.

STATE AND FEDERAL OPIOID USE DISORDER GRANTS

Funding is available through state and federal grants for the treatment of Opioid Use Disorder for uninsured and underinsured citizens of Arizona. You can find out more about these programs by visiting our website or calling Member Services.

HOUSING SERVICES

Supportive Housing is a service available for Arizona Complete Health-Complete Care Plan members which helps individuals secure safe and stable housing to live independently in the community of their choice. Regional Behavioral Health Authorities contract with Provider Agencies/Organizations which offer housing services consistent with Substance Abuse and Mental Health Services Administration (SAMHSA's) Evidenced Based Practice of permanent

supportive housing. Regional Behavioral Health Authorities collaborate with system partners such as the US Department of Housing & Urban Development, Arizona Department of Housing, local Housing Authorities and local Housing Continuum of Care Committees. The numbers of members that can be assisted with housing in any given year depends upon the funding level awarded by the State each year for this purpose. If you are interested in learning more about housing supports and services please call Arizona Complete Health-Complete Care Plan member Services at 1-888-788-4408 TTY/TDY 711.

PEER AND FAMILY SUPPORT RESOURCES

Peer Support Services and Family Support Services are behavioral health services available to our members. Peer Run Organizations are owned, managed, and staffed by people who have received mental health services. These organizations can provide a wide range of services to adult members, including peer support, living skills, vocational skills, re-entry support (support when coming out of prison), veterans' services, and entrepreneurship skills. Peer support services are provided by individuals who have shared similar life experience, they understand what you're going through. Family Run Organizations are governed by family members of children with mental health challenges. These organizations service families with children with behavioral, emotional and mental health challenges. They can provide services including family support, respite services, wellness and living skills, youth support, and vocational skills to families of children receiving behavioral health services. Call Member Services to find out more.

END OF LIFE CARE

End of Life care is a member centered approach with the goal of preserving member rights and maintaining member dignity while receiving any other medically necessary Medicaid covered services. End of Life care includes educating members and families about illness and treatment choices to keep them healthy and to afford them greater flexibility in deciding what their treatment course will be when faced with life limiting illness regardless of age or the stage of the illness. End of Life care allows members to receive advanced care planning, palliative care, supportive care, and hospice services and often includes the development of advance directives.

Specialty Services and Referrals

A referral is when your Arizona Complete Health-Complete Care Plan Care Manager, PCP or Behavioral Health Home sends you to a specialist for a specific service. Your Care Manager, PCP or Behavioral Health Home may want you to see a specialist or get special services. You may contact Arizona Complete Health-Complete Care Plan, Behavioral Health Home or your PCP if you feel you need a referral for specialized care. A referral can be to a specialty provider, lab or hospital. Your PCP or Behavioral Health Home will arrange for the specialty services listed below. Some of these specialty services may require Prior Authorization.

- Nutritional Assessments for members 21 years of age and older.
- Home health visits
- Organ transplants
- Skilled nursing home care
- Rehabilitation services like physical therapy, occupational therapy, or speech therapy
- Specialist care
- Surgery
- Certain x-rays, scans or medical tests
- Durable Medical Equipment such as wheelchairs or oxygen

You do not need a referral for the following specialty services:

- Emergency Services; including non-contracted out-of-network Emergency Departments
- Urgent Care Services
- Most behavioral health outpatient services (see *Behavioral Health Services* section for more information)
- OB/GYN services
- Dental services for children under the age of 21

Please note: Individuals can have a Pap smear or mammogram screening *(after age 40 and at any age if considered medically necessary)* once a year without a referral from their PCP. Please contact Member Services for more information on Pap smears and colonoscopies.

We may need to review and approve certain referrals and special services before you can get the services. Some medical services and specialists need our prior approval. If they do, your Care Manager, PCP or Behavioral Health Home will arrange for a Prior Authorization for these services. We must review these requests. Your Arizona Complete Health-Complete Care Plan Care Manager, PCP, Specialty Provider or Behavioral Health Home's office will let you know if your Prior Authorization request is approved. You can also call Member Services to find out the status of your request.

IN-NETWORK REFERRALS AND FREEDOM OF CHOICE OF PROVIDERS

You are required to use an Arizona Complete Health-Complete Care Plan in-network specialty provider. You can find Arizona Complete Health-Complete Care Plan contracted in-network specialty providers on our website at azcompletehealth.com/completecare. Arizona Complete Health-Complete Care Plan offers members the freedom of choice in selecting doctors and specialists in our network.

DENIAL OF REQUESTS FOR SPECIALTY SERVICES

If your specialty provider request is denied, we will let you know by mail. Our letter will also tell you how to appeal our decision if you are not happy with the decision. If you have a question about the denial, you may call Member Services at 1-888-788-4408 (TTY/TDY: 711). For more information about filing an appeal for a denied authorization, please see the section titled *"Complaints: What Should I Do if I Am Unhappy?"* in this handbook.

If you are getting Substance Use Disorder services that are funded by the Substance Abuse Block Grant (SABG), you have the right to get services from a provider to whose religious character you do not object. If you object to the religious character of your substance use disorder treatment provider, you may ask for a referral to another provider of substance use disorder treatment. You will get an appointment with the new provider within 7 days of your request for a referral, or earlier if needed. The new provider must be available to you and provide substance use disorder services that are similar to the services that you were receiving at the first provider. If you are having trouble accessing services due to the moral or religious objections of a provider, please call Member Services at 1-888-788-4408 (TTY/TDY: 711) for assistance with finding a provider that can meet your needs.

MEMBERS WHO ARE AMERICAN INDIAN

American Indian members are able to receive health care services from any Indian Health Service provider or tribally owned and/or operated facility at any time.

Your Primary Care Provider (PCP)

Your Primary Care Provider (PCP) or Behavioral Health Home facilitates your access to services. Your PCP or Behavioral Health Home may provide you medical services or your PCP or Behavioral Health Home may make plans for you to get these services from another provider (sometimes called a specialist). **You should always contact your PCP or Behavioral Health Home before you see any other provider or attempt to get outside services.**

You do not have to see your PCP or Behavioral Health Home for the following:

- Emergency Services
- Urgent Care Services
- Crisis Services
- Behavioral Health Services
- Substance Use Disorder Services
- OB/GYN services
- Dental services

Please note:

- Members can have a pap smear or mammogram screening *(after age 40 and at any age if considered medically necessary*) once a year without a referral from their PCP. Please contact Member Services for more information on Pap smears and colonoscopies.

HOW TO CHOOSE OR CHANGE A PRIMARY CARE PROVIDER (PCP)

It is important that you choose a PCP who makes you feel comfortable. When you have a PCP that you like, your PCP will be able to better help you with your health care. This relationship is very important in providing you the care you need. You can find a list of our doctors on our website at azcompletehealth.com/completecare or by calling Member Services at 1-888-788-4408, TTY/TDY 711.

If you wish to change your PCP, please call Member Services for assistance. A PCP change can be made effective the same date of the request. However, we encourage you not to change your PCP more than twice a year.

HOW CAN DOCTOR VISITS HELP YOU STAY HEALTHY?

- Make sure children under the age of 21 receive their annual well-exams [1]and immunizations.
- Adults ages 21 and older should receive their annual well-exams and should visit their PCP when a symptom or sickness develops or for regular care of a chronic condition.
- Schedule preventative exams such as Pap smear, Mammogram *(after age 40 and at any age if considered medically necessary)* and Cancer screening once a year. Talk to your doctor about other important screening and preventative tests, such as colonoscopies, prostate exams, diabetes tests, cholesterol tests.
- Keep your appointment for tests that your doctor has ordered for you.
- Know why it is important for you to have the test done and what could happen if you don't have it done.
- Ask your doctor to help you learn how to take better care of yourself.

HOW TO MAKE, CHANGE, OR CANCEL AN APPOINTMENT

How to Make an Appointment:

- Call your PCP, dentist, or specialist to schedule your appointment
- Tell the provider's office: your name, your AHCCCS Identification (ID) number (this appears on the front of your Arizona Complete Health-Complete Care Plan ID card), your doctor's name, and why you need to see this doctor.

How to Change an Appointment:

[1] **A well-child visit/check is the same as an Early Periodic Screening, Diagnostic and Treatment (EPSDT) visit.*

- Call your doctor's office at least 24 hours ahead of time
- Tell the doctor's office: your name, your AHCCCS ID number, the date of your appointment, and ask to set a new date to see your doctor.

How to Cancel your Appointment:

- Call your doctor's office 24 hours ahead of time.
- Tell the doctor's office that you want to cancel your appointment and provide them with: your name, your AHCCCS ID number, and the date of your appointment.
- If already arranged, call Member Services to cancel transportation or interpreter services when no longer needed.

If you are unable to contact your doctor's office and need help, please call Arizona Complete Health-Complete Care Plan Member Services.

Appointment availability – How long should it take to see a provider

When you call your provider to set up an appointment or get a referral for an appointment you should expect to see that provider within the timelines below:

- PCP Urgent: 2 business days
- PCP Routine: 21 calendar days
- Specialist Urgent: 3 business days
- Specialist Routine: 45 calendar days
- Dental Urgent: 3 business days
- Dental Routine: 45 calendar days
- Maternity Care 1st Trimester: 14 calendar days
- Maternity Care 2nd Trimester: 7 calendar days
- Maternity Care 3rd Trimester: 3 business days
- Maternity Care Risk: as required based on needs but no later than 3 business days
- Behavioral Health Urgent Need: 24 hours
- Behavioral Health Routine Initial Assessment: 7 calendar days
- Behavioral Health Routine First Service: 23 calendar days
- Behavioral Health Routine Subsequent Service: with time frames according to needs but no later than 45 days

- Referrals for Psychotropic Meds: in accordance to urgency of need but no later than 30 calendar days
- Rapid Response: 72 hours
- Rapid Response Initial Assessment: 7 calendar days
- Rapid Response Initial Appointment: 21 calendar days
- Rapid Response Subsequent Services: 21 calendar days

WELL VISITS

Well visits (well exams) such as, but not limited to, annual exams, breast exams, and prostate exams are covered for members 21 years of age and older. Most well visits (also called checkup or physical) include a medical history, physical exam, health screenings, health counseling and medically necessary immunizations. (See EPSDT for well exams for members under 21 years of age)

WELL-CHILD CARE / EARLY PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT)*

Early Periodic Screening, Diagnostic and Treatment (EPSDT) is a comprehensive child health program of prevention and treatment, correction, and improvement (amelioration) of physical and mental health problems for AHCCCS members under the age of 21.

The purpose of EPSDT is to ensure the availability and accessibility of health care resources, as well as to assist Medicaid recipients in effectively utilizing these resources.

EPSDT services provide comprehensive health care through primary prevention, early intervention, diagnosis, medically necessary treatment, and follow-up care of physical and behavioral health problems for AHCCCS members less than 21 years of age. EPSDT services include screening services, vision services, dental services, hearing services and all other medically necessary mandatory and optional services listed in federal law 42 U.S.C. 1396d(a) to correct or ameliorate defects and physical and mental illnesses and conditions identified in an EPSDT screening whether or not the services are covered under the AHCCCS state plan. Limitations and exclusions, other than the requirement for medical necessity and cost effectiveness do not apply to EPSDT services.

A well child visit is synonymous with an EPSDT visit and includes all screenings and services described in the AHCCCS EPSDT and dental periodicity schedules.

Amount, Duration and Scope: The Medicaid Act defines EPSDT services to include screening services, vision services, dental services, hearing services and “such other necessary health care, diagnostic services, treatment and other measures described in federal law subsection 42 U.S.C. 1396d(a) to correct or ameliorate defects and physical and mental illnesses and

conditions discovered by the screening services, whether or not such services are covered under the (AHCCCS) state plan."

This means that EPSDT covered services include services that correct or ameliorate physical and mental defects, conditions, and illnesses discovered by the screening process when those services fall within one of the 29 optional and mandatory categories of "medical assistance" as defined in the Medicaid Act. Services covered under EPSDT include all 29 categories of services in the federal law even when they are not listed as covered services in the AHCCCS state plan, AHCCCS statutes, rules, or policies as long as the services are medically necessary and cost effective.

EPSDT includes, but is not limited to, coverage of: inpatient and outpatient hospital services, laboratory and x-ray services, physician services, nurse practitioner services, medications, dental services, therapy services, behavioral health services, medical supplies, prosthetic devices, eyeglasses, transportation, and family planning services. EPSDT also includes diagnostic, screening, preventive and rehabilitative services. However, EPSDT services do not include services that are solely for cosmetic purposes, or that are not cost effective when compared to other interventions.

The Well-child* program includes the following procedures and tests to be performed as recommended by AHCCCS or at any time if medically indicated:

- Medical history evaluation
- Height and weight measurements, including Body Mass Index (BMI) for those 24 months and older
- Head circumference from birth to 24 months
- Blood pressure measurement - the need for blood pressure measurement for children from birth to 24 months should be assessed by PCP
- Nutritional assessment
- Vision assessment
- Hearing and speech assessment
- Developmental/behavioral assessment
- Physical Examination
- Immunizations
- Tuberculin (Tuberculosis) test (for members at risk between the ages of 12 months through age 20)
- Hematocrit/Hemoglobin testing
- Urinalysis testing
- Lead screening/Verbal testing
- Lead screening test and blood lead testing at ages 12 and 24 months and at 36 and 72 months if not previously tested

- Anticipatory guidance
- Dyslipidemia screening
- Dyslipidemia testing (one time testing between 18 and 20 years of age)
- STI Screening (risk assessment for those 11-20)
- Cervical Dysplasia Screening (risk assessment for those 11-20)
- Oral health assessments every 6 months.
- Fluoride varnish may be applied by the PCP during these visits beginning at 6 months of age with at least one tooth, and may be repeated every 6 months until the age of two years.
- Dental referral. First examination is encouraged to begin by age 1. Repeat dental visits every 6 months or as indicated by child's risk status or susceptibility to disease. For more information on dental care coverage, please see the "*Dental Care"* section in this handbook.

Well-child care will also give you ideas about how to:

- Keep your child well
- Protect your child from getting hurt
- Spot health problems early
- Apply for services like WIC, Head Start, Children's Rehabilitative Services (CRS), and the Arizona Early Intervention Program (AzEIP)

All children should see their doctor for well-child* visits regularly. Well-child checkups should be done at the following ages or at any other time if medically indicated:

- Newborn
- 3-5 days old
- 1 month
- 2 months old
- 4 months old
- 6 months old
- 9 months old
- 12 months old
- 15 months old
- 18 months old
- 24 months old
- Annually from 3 through 20 years old

We will send you a reminder about well-child checkups. Make an appointment with your PCP. It is important for your child to go to all the well-child checkups.

**A well-child visit/check is the same as an EPSDT.*

PREVENTATIVE AND WELL CARE

Female Members have direct access to preventive and well care services from a gynecologist within the Contractor's network without a referral from a primary care provider. Please contact Member Services for more information on Pap smears (a test for Cervical Cancer), mammograms (a test for Breast Cancer), and colonoscopies.

Our members can go directly to a network obstetrics/gynecology doctor for preventive and routine health care services. No referral is needed from your PCP.

Family Planning

Family Planning services are available to members of any gender who are of reproductive age. Family Planning will help you decide when to have children. Our providers can help you choose birth control methods that will work for you. Family Planning services require no copayment and are offered at no cost to you. You may seek family planning services from any network PCP or Gynecologist. No referral is needed from your PCP.

The following birth control methods are provided at no cost to you:

- Birth Control Counseling
- Birth control pills or Long Acting Reversible contraceptives (LARC), condoms, diaphragms, foams and suppositories
- Natural family planning and referral to qualified health professionals
- Post-coital emergency contraception (also known as the morning after pill)
- Sterilization only for members 21 years of age or older

Please note: That this is not an all-inclusive list of covered birth control methods.

The following services are not covered under Family Planning:

- Infertility services including testing, treatment, or reversal of a tubal sterilization or vasectomy
- Pregnancy termination counseling
- Pregnancy termination – unless you meet the conditions described in the "*Medically Necessary Pregnancy Termination*" section above.

- Hysterectomies if done for family planning only

We also want you to be able to get medical care if you lose your AHCCCS eligibility. This handbook contains a list of clinics that offer low cost or free medical care. Call the clinics to find out about services and costs. If you have questions or need help call Arizona Complete Health-Complete Care Plan Member Services at 1-888-788-4408, TTY/TDY 711.

If you lose eligibility for AHCCCS services, Arizona Complete Health-Complete Care Plan can help you find low-cost or no-cost family planning services, or you may call the Arizona Department of Health Services Hotline at 1-800-833-4642.

MATERNITY CARE

When you become pregnant, we want you to have a healthy pregnancy and a healthy baby. We have special programs that can help you throughout your pregnancy and after your baby's birth, and even can provide incentives for you to attend your appointments. If you find out that you are pregnant, please give us a call so we can tell you more about what we can offer and how we can work with you to have the best outcomes for your pregnancy. Please call Member Services at the numbers below. Maternity care includes identification of pregnancy prenatal care, labor and delivery services and postpartum care. It is important that you make and keep appointments with your doctor during your pregnancy. If you need help making an appointment, please call Member Services at 1-888-788-4408, TTY/TDY 711.

Maternity care coordination consists of the following maternity care related activities: determining the member's medical or social needs through a risk assessment evaluation; developing a plan of care designed to address those needs; coordinating referrals of the member to appropriate service providers and community resources; monitoring referrals to ensure the services are received; and revising the plan of care, as appropriate.

Preconception counseling services, as part of an annual visit, are provided when medically necessary. This counseling focuses on the early detection and management of risk factors before pregnancy, and includes efforts to influence behaviors that can affect a fetus (even before conception is confirmed), as well as regular health care. The purpose of preconception counseling is to ensure that an individual is healthy prior to pregnancy. Preconception counseling does not include genetic testing.

PREGNANCY IDENTIFICATION

As soon as you think you are pregnant, call your PCP to get a pregnancy test. Once you know that you are pregnant, it is important to choose a prenatal care provider. Please note: Your

prenatal care provider may also serve as your Primary Care Provider. Call Member Services to choose a prenatal care provider that is right for you. Then call the provider to make your first appointment. You will not need a referral to see a prenatal care provider. There are different types of prenatal care providers that you can choose from. You may choose a doctor that specializes in pregnancy (also known as Obstetrician), a Certified Nurse Midwife, a licensed midwife (if you are over the age of 18 and are not high risk), a nurse practitioner or a physician's assistant.

PRENATAL CARE

Prenatal care is the health care provided during pregnancy and is composed of three major components:

1. Early and continuous risk assessment
2. Health education and promotion, and
3. Medical monitoring, intervention, and follow-up.

Call and get your appointment as soon as you know you are pregnant. **Please note:** It is very important to go to all of your prenatal appointments as scheduled by your provider. During your prenatal care visits your provider may give this care:

- Checkups (including blood pressure check, check your weight, check your baby's movement and growth, and listen to your baby's heartbeat)
- Tests you may need, such as blood tests and urine tests to check that you are well.
- Check for infections, including sexually transmitted infections and HIV/AIDS. NOTE: Voluntary prenatal HIV testing and counseling is available to members.
- Give you prescriptions for prenatal vitamins or other medications the doctor prescribes.

When you find out you are pregnant, your provider must see you within:

- Fourteen (14) days if you are in your first trimester
- Seven (7) days if you are in your second trimester
- Three (3) days if you are in your third trimester
- Three (3) days if your pregnancy is high-risk or immediately if it is an emergency.

If you are not able to get an appointment within these time frames, call Member Services to assist you with getting a timely appointment. Call Member Services if you need a ride to your prenatal care appointments.

During your prenatal care visits, your provider will talk to you about staying healthy during your pregnancy. Your provider may talk about:

- Eating healthy foods

- Exercise during pregnancy
- Not smoking, not drinking alcohol or using other drugs during pregnancy.
- The normal pregnancy changes your body will go through
- When to call your provider right away for health changes.

At your first visit, your provider will also do a risk assessment to identify your medical, behavioral or social needs. Your questions and needs will show the doctor how a pregnancy will be set. At this time, your doctor will make referrals to community service offices and resources can be coordinated. Some examples of community service offices are Women, Infants and Children (WIC) and other state assistance programs like the Department of Economic Security (DES). DES provides financial aid to Arizona residents that qualify at application. Your pregnancy care plan may be changed as needed. If you need help during your pregnancy, call Member Services and we can help. Arizona Complete Health-Complete Care Plan has care managers to assist our providers with maternity care coordination. You can change providers or plans during your pregnancy. If you need help, the care managers can help you. Call Member Services if you need help for any of these reasons.

HIGH RISK PREGNANCY

High-risk pregnancy refers to a pregnancy in which the child-bearer, fetus, or newborn is, or is anticipated to be, at increased risk for morbidity or mortality before or after delivery. High-risk is determined through the use of the Medical Insurance Company of Arizona (MICA) or American College of Obstetricians and Gynecologists (ACOG) standardized medical risk assessment tools. These forms are completed by your OB physician during your visit with them

Your pregnancy may be high-risk if you or your baby have a medical or other condition that could make you or your baby sick while you are pregnant or after delivery.
Arizona Complete Health-Complete Care Plan has care managers that can help you with your high risk pregnancy at no cost to you. Our crse managers can answer your questions and help you with your appointments or referrals. If you want to talk to one of our care managers, please call Member Services at 1-888-788-4408, TTY/TDY 711.

LABOR AND DELIVERY CARE

When your baby is due (pregnancy usually is 40 weeks until delivery), your provider will deliver your baby at a hospital or birthing center. The hospitals are listed in the Provider Directory. If your pregnancy is not high risk, you may be able to deliver your baby at home with a licensed physician, practitioner or licensed midwife.

- Practitioner refers to certified nurse practitioners in midwifery, physician's assistants and other nurse practitioners.
- A Licensed Midwife is an individual licensed by the Arizona Department of Health Services to provide maternity care pursuant to Arizona Revised Statutes (A.R.S.) Title 36, Chapter 6, Article 7 and Arizona Administrative Code Title 9, Chapter 16. (This provider type does not include Certified Nurse Midwives licensed by the Board of Nursing as a nurse practitioner in midwifery or physician assistants licensed by the Arizona Medical Board.)
- A Certified Nurse Midwife (CNM) is certified by the American College of Nursing Midwives (ACNM) on the basis of a national certification examination and licensed to practice in Arizona by the State Board of Nursing. CNMs practice independent management of care for pregnant individuals and newborns, providing antepartum, intrapartum, postpartum, gynecological, and newborn care, within a health care system that provides for medical consultation, collaborative management, or referral.

POSTPARTUM CARE

Postpartum care is the health care provided for a period of up to 60 days post-delivery. This is called a postpartum visit. This final part of maternity care is very important and should not be avoided even if your delivery went well. Your provider will examine you for medical and behavioral health needs after your baby was born. Many individuals that have given birth can feel sad or depressed after their baby is born. Tell your provider if you have these feelings. Depression can be treated. It is important to let someone know if you are feeling depressed. Family planning services are included if provided by a physician or a practitioner. Call Member Services to schedule an appointment or if you need a ride to your postpartum care appointments.

HIV/AIDS TESTING

Voluntary, confidential HIV/AIDS testing services are available to members (**including prenatal members**), as well as counseling for members who test positive. Arizona Complete Health-Complete Care Plan can help. Call Arizona Complete Health-Complete Care Plan Member Services at 1-888-788-4408, TTY/TDY 711, for information about confidential testing or counseling services.

Important Note: Family Planning services are available to members of any gender who are of reproductive age. You may seek family planning services from any network PCP or Gynecologist. No referral is needed from your PCP. In cases where an in-network provider is not available, Arizona Complete Health-Complete Care Plan may authorize non-emergency out of network services or treatments.

MEDICALLY NECESSARY PREGNANCY TERMINATIONS

Pregnancy terminations are an AHCCCS covered service only in special situations. AHCCCS covers pregnancy termination if one of the following criteria is present:

1. The pregnant member suffers from a physical disorder, physical injury, or physical illness including a life-endangering physical condition caused by, or arising from, the pregnancy itself that would, as certified by a physician, place the member in danger of death, unless the pregnancy is terminated.
2. The pregnancy is a result of incest.
3. The pregnancy is a result of rape.
4. The pregnancy termination is medically necessary according to the medical judgment of a licensed physician, who attests that continuation of the pregnancy could reasonably be expected to pose a serious physical or behavioral health problem for the pregnant member by:
    a. Creating a serious physical or behavioral health problem for the pregnant member,
    b. Seriously impairing a bodily function of the pregnant member,
    c. Causing dysfunction of a bodily organ or part of the pregnant member,
    d. Exacerbating a health problem of the pregnant member, or
    e. Preventing the pregnant member from obtaining treatment for a health problem.

Dental Care

MEMBERS UNDER 21 YEARS OF AGE

All dental health checkups, cleanings and treatments are covered for members under the age of 21. A doctor referral is not needed to see a dentist. Two (2) routine and preventive dental visits are covered per year for members under the age of 21. It is important to take your children to the dentist twice a year to keep their teeth healthy. From the time the first tooth appears, children should visit their dentist for a checkup every six months.

Every member under age 21 needs to have a Dental Home. A Dental Home is an assigned dentist who will get you or your child the dental care that is needed. Call Member Services to select a dentist or one will be assigned. If a dentist is assigned that you do not want, or if you see a dentist already in our network and you are happy with that dentist please call Member Services at 1-888-788-4408 or TTY/TDY 711 to ask to keep that dentist.

Arizona Complete Health-Complete Care Plan sends dental checkup reminder letters to members. It is important to go to your scheduled visit because dentists can help prevent cavities. They can use dental sealants (a plastic coating painted on the back teeth) and fluoride treatments. Dentists also teach you and your child how to care for teeth. It is important to visit the dentist for checkups two times every year. Call Member Services if you need help finding a dental provider. Once you choose a dentist, you can call their office to make or change an appointment.

The following routine dental services are only covered for members under the age of 21:

- Dental exams
- Dental cleanings
- Fillings for cavities
- X-rays to screen for dental problems
- Application of fluoride
- Dental sealants
- Emergency dental services

Use these guidelines for scheduling appointments for your child:

- Emergency dental appointments – ask for a same-day appointment for extreme pain and dental emergencies.
- Urgent dental appointments – within 3 days for lost fillings, broken tooth.
- Routine dental appointments – within 45 days, for routine checkups and dental cleanings.
- Make sure you take your child's Arizona Complete Health-Complete Care Plan ID card with you to the dental appointment.

If you need to make, change, or cancel a dental appointment please contact your dentist or Arizona Complete Health-Complete Care Plan Member Service 1-888-788-4408 or TTY/TDY 711 for assistance.

MEMBERS 21 YEARS OF AGE AND OLDER

What if I am over 21 years old and have a dental emergency? Limited dental services are covered to relieve severe pain and or infection. Adult members 21 years of age and older can receive emergency dental services, limited to $1000 member per contract year. Emergency services over the $1000 benefit are the responsibility of the member.

Routine dental services are not covered for members 21 years of age or older. AHCCCS covers medical and surgical services related to dental (oral) care only to the extent such services may be performed under State law by either a physician or by a dentist and the services would be considered physician services if done by a physician. Covered dental services for members 21

years of age and older must be related to the treatment of a medical condition such as loss of tooth/teeth due to trauma, cyst or tumor, or fracture of the jaw. Covered dental services include examining the mouth, x-rays, care of fractures of the jaw or mouth, giving anesthesia, and pain medication and/ or antibiotics.

What else is covered? Certain pre-transplant services related to the elimination of oral infections and treatment of oral disease (such as dental cleanings, filings, simple restorations, extractions) and prophylactic extraction of teeth in preparation for radiation treatment of cancer of the jaw, neck or head are also covered. These services are not part of the $1000 adult emergency dental limit.

Pharmacy Services

Our pharmacy program includes high-quality, cost-effective medication therapy. We work with providers and pharmacists to ensure that we cover medications used to treat a variety of conditions and diseases. When ordered by a provider, we cover prescription medications and certain over-the-counter medications.

Some medications require prior authorization or have limitations on age, dosage and maximum quantities. For some drugs, you must try another drug first – this is called step therapy. Please refer to the Arizona Complete Health-Complete Care Plan Preferred Drug List or PDL for more detail. Arizona Complete Health-Complete Care Plan will cover the drugs listed on our Preferred Drug List as long as they are medically necessary and appropriate. The Arizona Complete Health-Complete Care Plan PDL includes all medications covered on the related AHCCCS Preferred Drug List and include additional medications that are safe and effective.

The Arizona Complete Health-Complete Care Plan PDL can be found at azcompletehealth.com/completecare

WHAT IF A DRUG IS NOT ON THE PDL/FORMULARY?

The PDL is not a complete list of drugs covered by Arizona Complete Health-Complete Care Plan. If the medicine your doctor feels you need is not on our list of covered drugs and you can't take any other medication except the one prescribed, your doctor may request Prior Authorization from us.

Arizona Complete Health-Complete Care Plan will approve your request for an exception if the alternative drugs included on the formulary or additional restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

WHAT IF MY REQUEST IS DENIED?

- When Arizona Complete Health-Complete Care Plan denies a request for authorization, a *Notice of Adverse Benefit Determination* or *Notice of Decision (NOD)* is mailed to the member, and an explanation letter is mailed to the requesting provider. The member's Notice of Adverse Benefit Determination will advise the member on how to file an appeal.
- If Arizona Complete Health-Complete Care Plan is reducing, suspending or terminating an existing service, there are additional rights and rules that apply, other than just being able to file an appeal.

HOW TO FILL A PRESCRIPTION

All prescriptions should be filled at an in-network pharmacy. You can use our Provider Directory to find a pharmacy near you. You can access the Provider Director at azcompletehealth.com/completecare on the Find a Provider page. You can also call a Member Services Representative to help you find a pharmacy. At the pharmacy, you will need to provide the pharmacist with your prescription and your member ID card.

If you take medicine for an ongoing health condition, you can have your medicines mailed to your home. Arizona Complete Health-Complete Care Plan works with a company to give you this service, which you can get at no cost to you.

If you choose this option, your medicine comes right to your door. You can schedule your refills and reach pharmacists if you have questions.

Some specialty drugs are only covered when supplied by our specialty pharmacy provider. Most of these drugs do require a prior authorization.

If you have other insurance besides Medicare Part D, we will only pay the co-pays (if applicable) if the drug is also on our list of covered drugs.

For pharmacy issues or obtaining help after hours, on weekends, or holidays (including if you are turned away from the pharmacy when you try to get your prescription), please contact Member Services at 1-888-788-4408 (TTY/TDY: 711) 24 hours a day, seven days a week.

WHAT YOU NEED TO KNOW ABOUT YOUR NEW PRESCRIPTION

Your doctor or dentist may give you a prescription for medication. Be sure and let your doctor know about any medications you get from other doctors or medications you buy on your own including non-prescription or herbal products.

When you pick up your prescription, the pharmacist will talk to you about your new prescription. Ask your pharmacist about how to take your medication and about any side effects that could happen. The pharmacy will also give you printed drug information when you fill your prescription. It will explain what you should and should not do and possible side effects.

REFILLS

The label on your medication bottle tells you how many refills your doctor has ordered for you. If your doctor has ordered refills, you may only get up to one 30-day fill at a time. Call your pharmacy for a refill; they will tell you when you can pick it up.

If your doctor has not ordered refills, you or the pharmacy must call your doctor before your medication runs out. Talk to your doctor or pharmacy about getting a refill. The doctor may want to see you before giving you a refill.

WHAT SHOULD I DO IF THE PHARMACY CANNOT FILL MY PRESCRIPTION?

Call Member Services and we can help find out why your prescription cannot be filled. Sometimes a primary insurance may be entered wrong or it may be too soon to refill. Other times the medication is not on our Drug List – our list of covered drugs. If the pharmacy turns you away or will not fill your prescription, ask if you and the pharmacist can call Member Services together to find what is happening. We will work with you and the pharmacy to find the best options for you.

EXCLUSIVE PHARMACIES

Arizona Complete Health-Complete Care Plan wants to keep members safe. Arizona Complete Health-Complete Care Plan may assign members to a Pharmacy Home or exclusive pharmacy. Exclusive pharmacies are chosen by the member or assigned by Arizona Complete Health-Complete Care Plan to provide all medically necessary medications. Members may be assigned exclusive pharmacies if:

You have utilized the following in a 3 month time period:
More than 4 prescribers;
and
More than 4 different abuse potential drugs;
and
More than 4 Pharmacies.
OR

You have received 12 or more certain medications in the past three months.
OR
You have presented a forged or altered prescription to the pharmacy.\

How to Access Behavioral Health Services from Arizona Complete Health-Complete Care Plan

Your Primary Care Physician (PCP) may be able to help you if you have mild depression, "postpartum" depression, anxiety and attention deficit hyperactivity disorder (ADHD). Your PCP may give you medicine, watch how the medicine is working and order different tests for your illness. **You do not need a referral from your PCP for behavioral health services.**

As an AHCCCS member, you are also entitled to a wide range of mental health/behavioral health benefits, including medications. Drugs ordered by your provider are part of your benefit.

RECEIVING BEHAVIORAL HEALTH SERVICES IF YOU ARE ENROLLED WITH CMDP, DDD, OR ARE DESIGNATED AS SERIOUSLY MENTALLY ILL

If you are enrolled with CMDP, DDD, or are designated as Seriously Mentally Ill, you will receive your mental health/behavioral health benefits, including medications, from Arizona Complete Health-Complete Care Plan Regional Behavioral Health Authority (RBHA).

Your AHCCCS ID card has our Member Services phone number to call to access behavioral health and substance use services. Services are assigned to a provider based on where you live. If you have questions or need help getting behavioral health services, please call Arizona Complete Health-Complete Care Plan's Member Services.

ELIGIBILITY FOR BEHAVIORAL HEALTH SERVICES

The following members are eligible for behavioral health services:

- Persons AHCCCS eligible through either Title 19 (Medicaid) or Title 21;
- Persons determined to have a Serious Mental Illness; and
- Special populations who are eligible to receive services funded through federal block grants.

Title 19 (Medicaid; may also be called AHCCCS) is insurance for low-income persons, children, and families. It pays for medical, dental (for children up to 21 years of age), and behavioral health services.

Title 21 (May also be called AHCCCS) is insurance for children under the age of 19 who do not have insurance and are not eligible for Title 19 benefits. It pays for medical, dental, and behavioral health services.

A Serious Mental Illness (SMI) is a mental disorder in persons 18 years of age or older that is severe and persistent. Persons may be so impaired that they cannot remain in the community without treatment and/or services. Crisis Response Network, a contracted provider with Arizona Complete Health-Complete Care Plan, will make a determination of Serious Mental Illness upon referral/request.

HOW TO ACCESS BEHAVIORAL HEALTH SERVICES

Arizona Complete Health-Complete Care Plan contracts with a variety of providers to meet your behavioral health needs. Contracted providers are chosen very carefully. They must meet strict requirements to care for our members, and we regularly check the care they give you. Arizona Complete Health-Complete Care Plan's provider network covers a broad geographic area so that you may receive services close to where you live and work. Our provider network offers culturally sensitive, individualized and comprehensive service options for children and families, persons determined to have a serious mental illness (SMI) and those with general mental health and substance abuse issues. You can select a provider from our provider directory or call Member Services for assistance.

ARIZONA'S VISION FOR THE DELIVERY OF BEHAVIORAL HEALTH SERVICES

All behavioral health services are delivered according to the following system principles. AHCCCS supports a behavioral health delivery system that includes:

1. Easy access to care,
2. Behavioral health recipient and family member involvement,
3. Collaboration with the Greater Community,
4. Effective Innovation,
5. Expectation for Improvement, and
6. Cultural Competency.

THE TWELVE PRINCIPLES FOR THE DELIVERY OF SERVICES TO CHILDREN:

1. Collaboration with the child and family:
   a. Respect for and active collaboration with the child and parents is the cornerstone to achieving positive behavioral health outcomes, and
   b. Parents and children are treated as partners in the assessment process, and the planning, delivery, and evaluation of behavioral health services, and their preferences are taken seriously.

2. Functional outcomes:
   a. Behavioral health services are designed and implemented to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults, and
   b. Implementation of the behavioral health services plan stabilizes the child's condition and minimizes safety risks.

3. Collaboration with others:
   a. When children have multi-agency, multi-system involvement, a joint assessment is developed and a jointly established behavioral health services plan is collaboratively implemented,
   b. Client-centered teams plan and deliver services, and
   c. Each child's team includes the child and parents and any foster parents, any individual important in the child's life who is invited to participate by the child or parents. The team also includes all other persons needed to develop an effective plan, including, as appropriate, the child's teacher, the child's DCS and/or DDD caseworker, and the child's probation officer.

   d. The team:
      i. Develops a common assessment of the child's and family's strengths and needs,
      ii. Develops an individualized service plan,
      iii. Monitors implementation of the plan, and
      iv. Makes adjustments in the plan if it is not succeeding.

4. Accessible services:
   a. Children have access to a comprehensive array of behavioral health services, sufficient to ensure that they receive the treatment they need,
   b. Case management is provided as needed,
   c. Behavioral health service plans identify transportation the parents and child need to access behavioral health services, and how transportation assistance will be provided, and
   d. Behavioral health services are adapted or created when they are needed but not available.

5. Best practices:

a. Behavioral health services are provided by competent individuals who are trained and supervised,
b. Behavioral health services are delivered in accordance with guidelines that incorporate evidence-based "best practices."
c. Behavioral health service plans identify and appropriately address behavioral symptoms that are reactions to death of a family member, abuse or neglect, learning disorders, and other similar traumatic or frightening circumstances, substance abuse problems, the specialized behavioral health needs of children who are developmentally disabled, maladaptive sexual behavior, including abusive conduct and risky behavior, and the need for stability and the need to promote permanency in class members' lives, especially class members in foster care, and
d. Behavioral health services are continuously evaluated and modified if ineffective in achieving desired outcomes.

6. Most appropriate setting:
   a. Children are provided behavioral health services in their home and community to the extent possible, and
   b. Behavioral health services are provided in the most integrated setting appropriate to the child's needs. When provided in a residential setting, the setting is the most integrated and most home-like setting that is appropriate to the child's needs.

7. Timeliness:
   a. Children identified as needing behavioral health services are assessed and served promptly.

8. Services tailored to the child and family:
   a. The unique strengths and needs of children and their families dictate the type, mix, and intensity of behavioral health services provided, and
   b. Parents and children are encouraged and assisted to articulate their own strengths and needs, the goals they are seeking, and what services they think are required to meet these goals.

9. Stability:
   a. Behavioral health service plans strive to minimize multiple placements,
   b. Service plans identify whether a class member is at risk of experiencing a placement disruption and, if so, identify the steps to be taken to minimize or eliminate the risk,
   c. Behavioral health service plans anticipate crises that might develop and include specific strategies and services that will be employed if a crisis develops,
   d. In responding to crises, the behavioral health system uses all appropriate behavioral health services to help the child remain at home, minimize placement disruptions, and avoid the inappropriate use of the police and the criminal justice system, and
   e. Behavioral health service plans anticipate and appropriately plan for transitions in children's lives, including transitions to new schools and new placements, and transitions to adult services.

10. Respect for the child and family's unique cultural heritage:
    a. Behavioral health services are provided in a manner that respects the cultural tradition and heritage of the child and family, and
    b. Services are provided in Spanish to children and parents whose primary language is Spanish.

11. Independence:
    a. Behavioral health services include support and training for parents in meeting their child's behavioral health needs, and support and training for children in self-management, and
    b. Behavioral health service plans identify parents' and children's need for training and support to participate as partners in the assessment process, and in the planning, delivery, and evaluation of services, and provide that such training and support, including transportation assistance, advance discussions, and help with understanding written materials, will be made available.

12. Connection to natural supports:
    a. The behavioral health system identifies and appropriately utilizes natural supports available from the child and parents' own network of associates, including friends and neighbors, and from community organizations, including service and religious organizations.

NINE GUIDING PRINCIPLES FOR RECOVERY-ORIENTED ADULT BEHAVIORAL HEALTH SERVICES AND SYSTEMS

1. Respect - Respect is the cornerstone. Meet the person where they are without judgment, with great patience and compassion.

2. Persons in recovery choose services and are included in program decisions and program development efforts - A person in recovery has choice and a voice. Their self-determination in driving services, program decisions and program development is made possible, in part, by the ongoing dynamics of education, discussion, and evaluation, thus creating the "informed consumer" and the broadest possible palette from which choice is made. Persons in recovery should be involved at every level of the system, from administration to service delivery.

3. Focus on individual as a whole person, while including and/or developing natural supports - A person in recovery is held as nothing less than a whole being: capable, competent, and respected for their opinions and choices. As such, focus is given to empowering the greatest possible autonomy and the most natural and well-rounded lifestyle. This includes access to and involvement in the natural supports and social systems customary to an individual's social community.

4. Empower individuals taking steps towards independence and allowing risk taking without fear of failure - A person in recovery finds independence through exploration, experimentation, evaluation, contemplation and action. An atmosphere is maintained whereby steps toward independence are encouraged and reinforced in a setting where both security and risk are valued as ingredients promoting growth.

5. Integration, collaboration, and participation with the community of one's choice - A person in recovery is a valued, contributing member of society and, as such, is deserving of and beneficial to the community. Such integration and participation underscores one's role as a vital part of the community, the community dynamic being inextricable from the human experience. Community service and volunteerism is valued.

6. Partnership between individuals, staff, and family members/natural supports for shared decision making with a foundation of trust - A person in recovery, as with any member of a society, finds strength and support through partnerships. Compassion-based alliances with a focus on recovery optimization bolster self-confidence, expand understanding in all participants, and lead to the creation of optimum protocols and outcomes.

7. Persons in recovery define their own success - A person in recovery -- by their own declaration -- discovers success, in part, by quality of life outcomes, which may include an improved sense of well-being, advanced integration into the community, and greater self-determination. Persons in recovery are the experts on themselves, defining their own goals and desired outcomes.

8. Strengths-based, flexible, responsive services reflective of an individual's cultural preferences - A person in recovery can expect and deserves flexible, timely, and responsive services that are accessible, available, reliable, accountable, and sensitive to cultural values and mores. A person in recovery is the source of their own strength and resiliency. Those who serve as supporters and facilitators identify, explore, and serve to optimize demonstrated strengths in the individual as tools for generating greater autonomy and effectiveness in life.

9. Hope is the foundation for the journey towards recovery - A person in recovery has the capacity for hope and thrives best in associations that foster hope. Through hope, a future of possibility enriches the life experience and creates the environment for uncommon and unexpected positive outcomes to be made real. A person in recovery is held as boundless in potential and possibility.

Multispecialty Interdisciplinary Clinics

CHILDREN'S REHABILITATIVE SERVICES (CRS) PROVIDER: MULTISPECIALTY INTERDISCIPLINARY CLINICS

If your child is diagnosed with certain conditions, they are eligible for services from special providers through a program called Children's Rehabilitative Services (CRS). These providers are called Multispecialty Interdisciplinary Clinics. Members with qualifying CRS conditions may choose to obtain services from any in-network Health Plan contracted provider; including, Multispecialty Interdisciplinary Clinics (MSICs) which serve as Health Homes that provide multi-specialty services to members with complex needs. At the MSIC, you and your family can see all of your medical specialists, benefit from community involvement and conveniently receive support services in one location.

If AHCCCS determines that your child is eligible for the CRS program, your child will be enrolled in a plan with a CRS provider.

Once your child is a CRS Member, your child will receive an Identification (ID) card.
The ID card has your child's name, CRS ID number, and other important information.

The type of CRS medical provider who will treat your child's condition will depend on your child's special health care need. Your child's CRS medical provider may be one of the following:

- Surgeon: General pediatric surgeon, Cardiovascular and thoracic surgeon, Ear, Nose and Throat (ENT) surgeon, Neurosurgeon, Ophthalmology surgeon, Orthopedic surgeons (general, hand, scoliosis, amputee), Plastic surgeons
- Medical Specialist: Cardiologist, Neurologist, Rheumatologist, General Pediatrician, Geneticist, Urologist, Metabolic Specialist
- Dental Provider: Dentist, Orthodontist

For more details on the clinic's specialties, you can visit the clinic's website or contact the clinic directly; or you may call Arizona Complete Health-Complete Care Plan Member Services at 1-888-788-4408 (TTY/TDY: 711). CRS Multispecialty Interdisciplinary Clinics are at the following locations:

DMG Children's Rehabilitative Services
3141 N. 3rd Ave
Phoenix, AZ 85013
1-602-914-1520
1-855-598-1871
www.dmgcrs.org
DMG Children's Rehabilitative Services specializes in the following services: Audiology, Cardiology, Endocrinology, ENT, Gastroenterology, Genetics, Lab and X-Ray, Neurology, Neurosurgery, Nutrition, Occupational Therapy, Ophthalmology, Orthopedics, Pediatric

Surgery, Physical Therapy, Plastic Surgery, Primary Care, Psychology, Rheumatology, Scoliosis, Speech and Language Rehabilitation, and Urology.

Children's Clinics
Square & Compass Building
2600 North Wyatt Drive
Tucson, AZ 85712
1-520-324-5437
1-800-231-8261
www.childrensclinics.org
Children's Clinics specializes in the following services: Anesthesiology, Audiology, Cardiology, Child Life, Dental and Orthodontia, Educational Support, Endocrinology, ENT, Gastrointestinal, Genetics, Lab and X-Ray, Hematology, Nephrology, Neurosurgery, Nursing Services, Nutrition, Occupational Therapy, Orthopedics, Ophthalmology, "Our Best Friends" Pet Therapy Program, Patient and Family Services, Pediatric Surgery, Physical Medicine, Physical Therapy, Plastic Surgery, Primary Care, Psychology, Pulmonology, Rheumatology, Speech and Language Therapy, and Urology.

Children's Rehabilitative Services
1200 North Beaver
Flagstaff, AZ 86001
1-928-773-2054
1-800-232-1018
www.flagstaffmedicalcenter.com

Flagstaff Medical Center specializes in the following services: Audiology, Bariatric Surgical Weight Loss, Behavioral Health, Cancer Centers, Children's Health Center, Diabetes, Emergency Care, Endocrinology, Gastroenterology, Surgical Services, Fit Kids, Heart and Vascular, Infectious Diseases. Neurology, Nutrition Services, Ophthalmology, Orthopedics, Pulmonary, Renal Services, Sleep Center, Trauma Services, EntireCare Therapy, and Urology.

Children's Rehabilitative Services
2400 Avenue A
Yuma, AZ 85364
1-928-336-7095
1-800-837-7309
www.yumaregional.org

Yuma Regional Medical Center specializes in the following services: Cardiology, Gastroenterology, Neonatal ICU, Nephrology, Neurology, Rheumatology, Surgery, and Urology.

HOW TO MAKE, CHANGE OR CANCEL AN APPOINTMENT WITH A CRS CLINIC

Your child needs to have an appointment to see a CRS provider. If you don't make an appointment and just show up, the provider may not be able to see your child. When you call the Multispecialty Interdisciplinary Clinics (MSIC) to make an appointment, be ready to tell the person on the phone:

- Your child's name
- Your child's AHCCCS ID number, and
- The reason your child needs an appointment.

Your child's appointment will be made based on when your provider needs to see your child or within 45 days. If your child has an urgent need, your child can see your provider sooner. If you think your child's appointment needs to be made sooner, you can ask to be seen at an earlier date. Please tell the provider why you think your child needs to be seen quickly and ask for an earlier appointment.

If you need to cancel or change an appointment, please tell your child's provider or your clinic at least one day before the appointment. If you need to cancel an appointment, please be sure to make an appointment for another time.

Children's Rehabilitative Services (CRS)

What is CRS?

Children's Rehabilitative Services (CRS) is a designation given to certain AHCCCS members who have qualifying health conditions. Members with a CRS designation can get the same AHCCCS covered services as non-CRS AHCCCS members and are able to get care in the community, or in clinics called multispecialty interdisciplinary clinics (MSIC). MSICs bring many specialty providers together in one location. Your health plan will assist a member with a CRS designation with closer care coordination and monitoring to make sure special healthcare needs are met.

Eligibility for a CRS designation is determined by the AHCCCS Division of Member Services (DMS).

Who is Eligible for a CRS Designation?

AHCCCS members may be eligible for a CRS designation when they are:

- Under age 21; and
- Have a qualifying CRS medical condition

The medical condition must:

- Require active treatment; and
- Be found by AHCCCS DMS to meet criteria as specified in R9-22-1301-1305.

Anyone can fill out a CRS application including a family member, doctor, or health plan representative. To apply for a CRS designation mail or fax:

- A completed CRS application; and
- Medical documentation that supports that the applicant has a CRS qualifying condition that requires active treatment.

Arizona Complete Health-Complete Care Plan will provide medically necessary care for physical and behavioral health services and care for the CRS condition.

CONDITIONS COVERED THROUGH THE CRS PROGRAM

CRS covers many chronic and disabling health conditions. Some of the eligible conditions include, but are not limited to:

- Cerebral palsy
- Club feet
- Dislocated hips
- Cleft palate
- Scoliosis
- Spina bifida
- Heart conditions due to congenital anomalies
- Metabolic disorders
- Neurofibromatosis
- Sickle cell anemia
- Cystic Fibrosis

EARLY CHILDHOOD SERVICES*

If you are concerned that your child is not growing like other children of the same age, tell your pediatrician or family doctor. Your doctor can refer you to specialists to learn if your child is on track with talking, moving, using hands and fingers, seeing and hearing. If your child is behind in one or more of these areas, services are available to help you help your child improve in these areas. The doctor may refer you to the Arizona Early Intervention Program (AzEIP) if your child is birth to three years of age and has a delay. To learn more about other community programs for children with special needs call Member Services at 1-888-788-4408 (TTY/TDY: 711).

*A well-child visit/check is the same as an EPSDT.

HEAD START

Arizona Head Start Programs provide high quality programs for preschool age children that include early childhood education, nutrition, health, mental health, disabilities and social services. In some areas there are early Head Start programs for infants and toddlers three years of age. There are Head Start Services at over 500 locations throughout the State of Arizona. For

more information about the Head Start nearest you, call 1-866-763-6481. You will need your address and zip code when you call.

DEVELOPMENTAL SCREENING TOOLS

Developmental screening tools used by PCPs providing care for children include:

- For members who are 9, 18 and 24 months of age, the Parent's Evaluation of Developmental Status (PEDS) tool and the Ages and Stages Questionnaire (ASQ).
- For members 16-30 months of age, the Modified Checklist for Autism in Toddlers (MCHAT), to screen for autism when medically indicated.

Special Assistance

Special Assistance is a unique clinical designation providing support to members with an SMI determination. Qualifying members must have an inability to communicate and/or participate during treatment planning and have a qualifying mental and/or physical condition. When a health home clinical team or other qualified assessor determines a member meets Special Assistance criteria they notify the Office of Human Rights. The Office of Human Rights will assign an individual to meet Special Assistance needs who advocates on behalf of the member during treatment planning.

Arizona Complete Health-Complete Care Plan works in collaboration with the AHCCCS Office of Human Rights to ensure members meeting Special Assistance criteria are appropriately identified.

You can reach the Individual & Family Affairs team by calling Member Services at 1-888-788-4408 (TTY/TDY: 711) and asking to speak to someone from the Individual & Family Affairs Team.

You can visit the AHCCCS Office of Human Rights page at:
https://www.azahcccs.gov/AHCCCS/HealthcareAdvocacy/ or call: 1-877-524-6882

Member Advocacy Council

You'll find Arizona Complete Health-Complete Care Plan's Advocate Team at work in community coalitions, committees, and workgroups promoting and protecting your rights as an AHCCCS member. Our advocacy team also holds monthly Member Advocacy Council meetings. This is an opportunity to have your voice heard and to learn about changes or updates in your health plan.

Arizona Complete Health-Complete Care Plan's Advocate Team is made up of the following staff:

Member Advocacy Administrator	Oversees Arizona Complete Health-Complete Care Plan's Advocacy team and works with members with special healthcare needs, families, youth, advocates and key stakeholders to promote and protect their rights. Works closely with regional Human Rights Committees and the Office of Human Rights.
Adult Behavioral Health Member Advocate	Focused on promoting and protecting the rights of adult members receiving behavioral health services. This includes Special Assistance and the Office of Human Rights.
Child Behavioral Health Member Advocate	Focused on promoting and protecting the rights of children receiving behavioral health services.
Veteran Member Advocate	Focused on promoting and protecting the rights of our veteran members receiving physical and/or behavioral health services.
CRS Member Advocate	Focused on promoting and protecting the rights of our members receiving physical and/or behavioral health services through the CRS program. Children's Rehabilitative Services (CRS) is an Arizona program that provides medical treatment to AHCCCS members with CRS-qualifying conditions. CRS members receive the same AHCCCS covered services as non-CRS AHCCCS members. Services are provided for the CRS condition and other medical and behavioral health services for most CRS members. CRS members are able to receive care in the community, or in multispecialty interdisciplinary clinics (MSICs).

Please contact us at AzCHAdvocates@azcompletehealth.com for more information on advocacy or to be a part of our Member Advocacy Council.

Approval and Denial Process

Some medical and behavioral health services may need Prior Authorization. Prior Authorization means your doctor has requested permission for you to get a special service or referral. We must approve these requests before the delivery of services. For example, non-emergency hospital admissions or others such as:

- Behavioral Health Inpatient Facility

- Behavioral Health Residential Facility
- Home Care Training to Home Care Clients (HCTC)
- Psychological and Neuropsychological Testing
- Electroconvulsive Therapy (ECT)
- Non-emergency out of network services/treatments
- Some medications, check the list of approved medications (formulary)
- MRI, MRA, PET scans
- Special lab work, genetics
- Surgeries, pre-scheduled
- Dialysis
- Some Outpatient procedures and surgeries
- Transplant
- Bio pharmacy (Buy and Bill)

If they do, your provider will arrange for authorization for these services. We must review these authorization requests before you can get the service.

If you or your provider would like a referral to a service that is not a covered benefit, please call Member Services at 1-888-788-4408, TTY/TDY 711 so we can discuss other options available to you.

Prior Authorization is approved based on a review of medical need.

Your provider will let you know when authorization is obtained. You can also call Member Services to find out the status of the request. We will let you know by mail if authorization is denied. In the letter, you will have instructions on how to file an appeal. The letter will describe the reason for the denial. If you have a question about the denial and need help, please call Member Services at 1-888-788-4408, TTY/TDY 711. Please see the section titled *"Complaints: What Should I Do if I Am Unhappy?"* in this handbook for more information about filing an appeal about a denied authorization.

Criteria that decisions are based on are available upon request.

In-Network Referrals and Freedom of Choice of Providers

You are required to use a Health Plan in-network specialty provider. You can find Health Plan contracted in-network specialty providers on our website; azcompletehealth.com/completecare

The Health Plan offers members the freedom of choice in selecting doctors and specialists in our network. In cases where an in-network provider is not available, Arizona Complete Health-Complete Care Plan may authorize non-emergency out of network services or treatments.

Copayments

Some people who get AHCCCS Medicaid benefits are asked to pay copayments for some of the AHCCCS medical services that they receive.

*NOTE: Copayments referenced in this section means copayments charged under Medicaid (AHCCCS). It does not mean a person is exempt from Medicare copayments.

PERSONS THAT ARE NOT ASKED TO PAY COPAYMENTS:

- People under age 19,
- People determined to be Seriously Mentally Ill (SMI),
- An individual designated eligible for the Children's Rehabilitative Services program pursuant to as Title 9, Chapter 22, Article 13.
- ACC, CMDP, and RBHA members who are residing in nursing facilities or residential facilities such as an Assisted Living Home and only when member's medical condition would otherwise require hospitalization. The exemption from copayments for these members is limited to 90 days in a contract year,
- People who are enrolled in the Arizona Long Term Care System (ALTCS),
- People who are Qualified Medicare Beneficiaries,
- People who receive hospice care,
- American Indian members who are active or previous users of the Indian Health Service, tribal health programs operated under Public Law 93-638, or urban Indian health programs,
- People in the Breast and Cervical Cancer Treatment Program (BCCTP),
- People receiving child welfare services under Title IV-B on the basis of being a child in foster care or receiving adoption or foster care assistance under Title IV-E regardless of age,
- People who are pregnant and throughout postpartum period following the pregnancy, and
- Individuals in the adult Group (for a limited time**).

****NOTE**: For a limited time persons who are eligible in the Adult Group will not have any copays. Members in the Adult Group include persons who were transitioned from the

AHCCCS Care program as well as individuals who are between the ages of 19-64, and who are not entitled to Medicare, and who are not pregnant, and who have income at or below 133% of the Federal Poverty Level (FPL) and who are not AHCCCS eligible under any other category. Copays for persons in the Adult Group with income over 106% FPL are planned for the future. Members will be told about any changes in copays before they happen.

COPAYMENTS ARE NOT CHARGED FOR THE FOLLOWING SERVICES FOR ANYONE:

- Hospitalizations,
- Emergency services,
- Family Planning services and supplies,
- Pregnancy related health care and health care for any other medical condition that may complicate the pregnancy, including tobacco cessation treatment for pregnant individuals,
- Preventive services, such as well visits, pap smears, colonoscopies, mammograms and immunizations,
- Provider preventable services, and
- Services received in the emergency department.

PEOPLE WITH OPTIONAL (NON-MANDATORY) COPAYMENTS

Individuals eligible for AHCCCS through any of the programs below may be charged non-mandatory copays, unless:

1. They are receiving one of the services above that cannot be charged a copay, or
2. They are in one of the groups above that cannot be charged a copay.

Non-mandatory copays are also called optional copays. If a member has a non-mandatory copay, then a provider cannot deny the service if the member states that s/he is unable to pay the copay. Members in the following programs may be charged non-mandatory copay by their provider:

- AHCCCS for Families with Children (1931),
- Young Adult Transitional Insurance (YATI) for young people in foster care,
- State Adoption Assistance for Special Needs Children who are being adopted,
- Receiving Supplemental Security Income (SSI) through the Social Security Administration for people who are age 65 or older, blind or disabled,
- SSI Medical Assistance Only (SSI MAO) for individual who are age 65 or older, blind or disabled,
- Freedom to Work (FTW).

Ask your provider to look up your eligibility to find out what copays you may have. You can also find out by calling Arizona Complete Health-Complete Care Plan member services. You can also check the Arizona Complete Health-Complete Care Plan website for more information.

AHCCCS members with non-mandatory copays may be asked to pay the following non-mandatory copayments for medical services:

OPTIONAL (NON-MANDATORY) COPAYMENT AMOUNTS FOR SOME MEDICAL SERVICES

SERVICE	COPAYMENT
Prescriptions	$2.30
Out-patient services for physical, occupational and speech therapy	$2.30
Doctor or other provider outpatient office visits for evaluation and management of your care	$3.40

Medical providers will ask you to pay these amounts but will **NOT** refuse you services if you are unable to pay. If you cannot afford your copay, tell your medical provider you are unable to pay these amounts so you will not be refused services.

PEOPLE WITH REQUIRED (MANDATORY) COPAYMENTS

Some AHCCCS members have required (or mandatory) copays unless they are receiving one of the services above that cannot be charged a copay or unless they are in one of the groups above that cannot be charged a copay. Members with required copays will need to pay the copays in order to get the services. Providers can refuse services to these members if they do not pay the mandatory copays. Mandatory copays are charged to persons in Families with Children that are no Longer Eligible Due to Earnings - also known as Transitional Medical Assistance (TMA)

Adults on TMA have to pay required (or mandatory) copays for some medical services. If you are on the TMA Program now or if you become eligible to receive TMA benefits later, the notice from DES or AHCCCS will tell you so. Copays for TMA members are listed below.

REQUIRED (MANDATORY) COPAYMENT AMOUNTS FOR PERSONS RECEIVING TMA BENEFITS

SERVICE	COPAYMENT
Prescriptions	$2.30
Doctor or other provider outpatient office visits for evaluation and management of your care	$4.00

Physical, Occupational and Speech Therapies	$3.00
Outpatient Non-emergency or voluntary surgical procedures	$3.00

Pharmacists and Medical Providers can refuse services if the copayments are not made.

5% LIMIT ON ALL COPAYMENTS

The amount of total copays cannot be more than 5% of the family's total income (before taxes and deductions) during a calendar quarter (January through March, April through June, July through September, and October through December.) The 5% limit applies to both nominal and required copays.

AHCCCS Administration will track each member's specific copayment levels to identify members who have reached the 5% copayment limit. If you think that the total copays you have paid are more than 5% of your family's total quarterly income and AHCCCS has not already told you this has happened, you should send copies of receipts or other proof of how much you have paid to *AHCCCS, 801 E. Jefferson, Mail Drop 4600, Phoenix, Arizona 85034.*

If you are on this program but your circumstances have changed, contact your local DES office to ask them to review your eligibility. Members can always request a reassessment of their 5% limit if their circumstances have changed.

COPAYMENTS FOR NON-TITLE XIX/XXI MEMBERS

Non-Title XIX/XXI persons determined to have a Serious Mental Illness (SMI) may have to pay copayments for behavioral health services. The copayment amount is $3. Prior to your appointment for services, Arizona Complete Health-Complete Care Plan or your provider will discuss with you any payments you will have to pay.

If you have Medicare or private insurance, you will pay the $3 copayment for services covered by Arizona Complete Health-Complete Care Plan, or the copayment that your insurance requires (if it is less than $3) for those services. In other words, you will not have to pay a higher payment for Arizona Complete Health-Complete Care Plan covered services, just because you have other insurance. However, if you are getting services through your insurance for services or medications that Arizona Complete Health-Complete Care Plan does not cover; (see the Available Services Matrix on starting on page 23) you will be responsible for paying the copayment or other fees that your insurance requires.

You may have to pay for non-covered services. Examples of non-covered services may include:

1. A service that your provider did not set up or approve,

2. A service that is not listed on the Available Services Matrix on page 25, or
3. Or A service that you receive from a provider outside of the provider network without a referral.

PAYING FOR COVERED SERVICES

Only in very limited circumstances should you be asked to pay for covered services. Doctors, hospitals, and pharmacies can verify your coverage through AHCCCS or by calling Arizona Complete Health-Complete Care Plan Member Service. If you have been asked to pay for a covered service or if you have received a bill for covered services, please contact Member Services to discuss your options for reimbursement.

PAYING FOR NON-COVERED SERVICES

We will only cover care approved by our plan, unless it is an Emergency Service. If you obtain a service or prescription that is not covered by our plan, Arizona Complete Health-Complete Care Plan will not be responsible for payment.

Coordination Of Benefits (COB)

If you are a member with “other insurance” or are “dual eligible” (which means that you also have Medicare coverage), please take a moment to call Member Services to let us know. When you call us, we will make sure we have the other insurance listed in our system.

You may also call the AHCCCS eligibility office to let them know. AHCCCS will then pass the information on to us. Remember, this also includes insurance coverage through divorce or if your child has insurance that is paid by your former spouse. Sometimes, members with other types of insurance such as Tricare or other commercial plans are approved for AHCCCS. We are responsible for making any co-payment, coinsurance or deductibles, even if the services are provided outside of our network.

If a third party insurer (other than Medicare) requires the member to pay any co-payment, coinsurance or deductible, we are responsible for paying the lesser of the difference between:

- The Primary Insurance Paid amount and the Primary Insurance Rate (i.e., the member’s co-payment required under the Primary Insurance).

OR

- The Primary Insurance Paid amount and the AHCCCS Fee for Service Rate, even if the

services are provided outside of the network.

We are not responsible for paying coinsurance and deductibles that are more than what we would have paid for the entire service per the contract with the provider performing the service, or the AHCCCS equivalent.

Special Information for our Members who have Medicare Coverage

If you are a “dual eligible” member, it often means that you have additional benefits that may not be covered under AHCCCS. When we know about your other insurance, it helps us coordinate the care you receive with the other plan.

If you have Medicare coverage and you see a doctor that is not on our plan, the charges may not be covered. If you choose to do that without our approval, we may not pay for those services because they were done by a doctor that is not on our plan. It is important that you work with your PCP to be referred to the right doctors. (This does not include emergency services.) We will not cover copays or deductibles for services provided outside of the network without Prior Authorization.

Dual eligible members have a choice of all providers in the network and are not restricted to those that accept Medicare.

Why should you call Member Services and let us know about the different coverage that you have? Because it will help you get the maximum benefits from both insurance plans!

Complaints: How to File and Complaint If I Am Unhappy

GRIEVANCES AND APPEALS

If you are dissatisfied with your services or disagree with a decision made about your services, make your voice heard by contacting the Arizona Complete Health-Complete Care Plan Grievance

and Appeals Department. The Arizona Complete Health-Complete Care Plan Grievance and Appeals Department will help you with the process for filing a grievance or an appeal.

You have the right to file a grievance regarding any covered service we provide; this includes or Title 19/21 AHCCCS eligible members, members determined to have a Serious Mental Illness; and members who are not enrolled as a person with Serious Mental Illness and are Non-Title 19/21 eligible.

DISSATISFIED WITH YOUR CARE?

If you are not happy with your care you may file a grievance. A grievance is a complaint. You may file a grievance against a service provider or against Arizona Complete Health-Complete Care Plan. Examples of grievances include delays in services and dissatisfaction with the quality of care or quality of service you received.

You may also file a grievance if you received a Notice of Adverse Benefit Determination that you do not understand or is not correct. If Arizona Complete Health-Complete Care Plan does not resolve your concern about the Notice, you may also contact the AHCCCS Medical Management at MedicalManagement@azahcccs.gov.

You may also file a grievance by calling the Member Services Department between 8:00 a.m. and 5:00 p.m. at 1-888-788-4408 or TTY/TDY 711.

You may also file a grievance in person or in writing. You may file your grievance in writing by mailing it to:

Arizona Complete Health – Complete Care Plan
Attn: Grievance and Appeals Department
1870 W. Rio Salado Parkway
Tempe, AZ 85281

Once filed, your grievance will be reviewed and a response will be provided no later than 90 days from the date that you contacted us. In most cases we will complete our review and provide a response within 10 calendar days.

LEGAL RIGHTS OF PERSONS WITH SERIOUS MENTAL ILLNESS

If you have a SMI designation, you have the right to file a grievance if you believe your rights were violated by a mental health provider. You may also request an investigation related to a condition requiring investigation (an incident or condition that appears to be dangerous, illegal, or inhumane). Your legal rights include (but are not limited to):

- The right to be free from unlawful discrimination;
- The right to equal access to behavioral health services;
- The right to privacy;
- The right to be informed; and
- The right to be assisted by an attorney or representative of your choosing.

See Arizona Administrative Code Title 9, Chapter 21, Article 2, for a more complete list of your civil and other legal rights.

If you feel your rights have been violated or a condition requiring investigation exists, please contact Arizona Complete Health-Complete Care Plan Member Service Department between 8:00 a.m. and 5:00 p.m. at 1-888-788-4408 or 7-1-1 TDD/TTY. We will help you with the process for initiating a grievance or requesting an investigation. You may also walk-in to the Arizona Complete Health-Complete Care Plan Regional Behavioral Health Authority office and request to speak to someone in person:

Arizona Complete Health-Complete Care Plan Regional Behavioral Health Authority
333 E. Wetmore Road, Suite 600
Tucson, AZ 85705

DISSATIFIED WITH A DECISION?

If you are not happy with a decision made about your services, you may file an Appeal. An appeal is a formal request to review a decision about your services. If you receive a Notice of Adverse Benefit Determination, you have the right to file an appeal. A Notice of Adverse Benefit Determination is a written letter that explains a decision about your services. Even if you did not receive a Notice of Adverse Benefit Determination, you may have the right to file an appeal.

You have appeal rights regarding any covered service we provide; this includes appeals for Title 19/21 AHCCCS eligible members, appeals for members determined to have a Serious Mental Illness (“SMI Appeals”); and appeals for members who are not enrolled as a person with Serious Mental Illness and are Non-Title 19/21 eligible.

HOW DO I FILE AN APPEAL?

Appeals can be filed orally or in writing within 60 days after the date of a Notice of Adverse Benefit Determination or Notice of Decision and Right to Appeal. The Notice explains to you how to file an appeal and what the deadline is for filing an appeal. However, if you have any questions the Arizona Complete Health-Complete Care Plan Grievance and Appeal Department is available to assist you. To reach a Grievance and Appeal Department representative, please contact Arizona Complete Health-Complete Care Plan Member Services.

You or your legal representative can file an appeal. An authorized representative, including a provider, can also file an appeal for you with your written permission. You can also get help with filing an appeal by yourself.

In some cases, Arizona Complete Health-Complete Care Plan will review an appeal on an expedited basis. An expedited appeal is resolved within 72 hours due to the urgent health needs of the person filing the appeal. Contact Arizona Complete Health-Complete Care Plan Member Services or your provider to see if your appeal will be expedited. If your appeal is not expedited it will be resolved within 30 calendar days of the date it is received.

To file an appeal orally or for help with filing a written appeal, call Arizona Complete Health-Complete Care Plan Member Services at 1-888-788-4408 or TTY/TDY 7-1-1. To file an appeal by mail, send your appeal and documentation to:

Arizona Complete Health-Complete Care Plan
Attn: Grievance & Appeal Department
1870 W. Rio Salado Parkway
Tempe, AZ 85281

You will get written notice that your appeal was received within 5 business days. If your appeal is expedited, you will get notice that your appeal was received within 1 business day. If Arizona Complete Health-Complete Care Plan has decided that your appeal does not need to be expedited, your appeal will follow the standard appeal timelines. Arizona Complete Health-Complete Care Plan will make reasonable efforts to give you prompt oral notice of the decision not to expedite your appeal and follow up within 2 calendar days with a written notice.

WHAT CAN I APPEAL?

You have the right to ask for a review of the following adverse benefit determinations:

- The denial or limited approval of a service asked for by your provider or clinical team;
- The reduction, suspension, or termination of a service that you were receiving;
- The denial, in whole or part, of payment for a service;
- The failure to provide services in a timely manner;

- The failure to act within timeframes for resolving an appeal or complaint; and
- The denial of a request for services outside of the provider network when services are not available within the provider network.

WHAT HAPPENS AFTER I FILE AN APPEAL?

As part of the appeal process, you have the right to give evidence that supports your appeal. You can provide the evidence to Arizona Complete Health-Complete Care Plan in person or in writing. In order to prepare for your appeal, you may examine your case file, medical records, and other documents and records that may be used before and during the appeal process, as long as the documents are not protected from disclosure by law. If you would like to review these documents, contact your provider or Arizona Complete Health-Complete Care Plan. The evidence you give to Arizona Complete Health-Complete Care Plan will be used when deciding the resolution of the appeal.

HOW IS MY APPEAL RESOLVED?

Arizona Complete Health-Complete Care Plan will give you a decision, called a Notice of Appeal Resolution, in person or by certified mail within 30 days of getting your appeal for standard appeals, or within 72 hours for expedited appeals. The Notice of Appeal Resolution is a written letter that tells you the results of your appeal.

The resolution date may be may be extended by up to 14 days. You or Arizona Complete Health-Complete Care Plan can ask for more time in order to gather more information. If Arizona Complete Health-Complete Care Plan asks for more time, you will be given written notice of the reason for the extension.

When we have completed our review, you will receive a Notice of Appeal Resolution that will tell you:

- The outcome of the appeal; and
- The reason(s) for the decision

If your appeal was denied, in whole or in part, then the Notice of Appeal Resolution will also tell you:

- How you can ask for a State Fair Hearing;
- How to ask that services continue during the State Fair Hearing process, if applicable;
- The reason why your appeal was denied and the legal basis for the decision to deny your appeal; and
- That you may have to pay for the services you get during the State Fair Hearing process if your appeal is denied at the State Fair Hearing.

WHAT CAN I DO IF I AM NOT HAPPY WITH MY APPEAL RESULTS?

You can ask for a State Fair Hearing if you are not happy with the results of an appeal. If your appeal was expedited, you can ask for an expedited State Fair Hearing. YOU HAVE THE RIGHT TO HAVE A REPRESENTATIVE OF YOUR CHOICE ASSIST YOU AT THE STATE FAIR HEARING.

HOW DO I ASK FOR A STATE FAIR HEARING?

You must ask for a State Fair Hearing in writing within 120 days of getting the Notice of Appeal Resolution. This includes both standard and expedited requests for a State Fair Hearing. Requests for State Fair Hearings should be mailed to:

Arizona Complete Health-Complete Care Plan
Attn: Grievance and Appeal Department
1870 W. Rio Salado Parkway
Tempe, AZ 85281

WHAT IS THE PROCESS FOR MY STATE FAIR HEARING?

You will receive a Notice of State Fair Hearing at least 30 days before your hearing is scheduled.

The Notice of State Fair Hearing is a written letter that will tell you:

- The time, place and nature of the hearing;
- The reason for the hearing;
- The legal and jurisdictional authority that requires the hearing; and
- The specific laws that are related to the hearing.

HOW IS MY STATE FAIR HEARING RESOLVED?

For standard State Fair Hearings, you will receive a written AHCCCS Director's Decision no later than 90 days after your appeal was first filed. This 90-day period does not include:

- Any timeframe extensions that you have requested; and
- The number of days between the date that you received the Notice of Appeal Resolution and the date your request for a State Fair Hearing was submitted.

The AHCCCS Director's Decision will tell you the outcome of the State Fair Hearing and the final decision about your services.

For expedited State Fair Hearings, you will receive a written AHCCCS Director's Decision within 3 working days after the date that AHCCCS receives your case file and appeal information from Arizona Complete Health-Complete Care Plan. AHCCCS will also try to call you to notify you of the AHCCCS Director's Decision.

WILL MY SERVICES CONTINUE DURING THE APPEAL/STATE FAIR HEARING PROCESS?

You may ask that the services you were already getting continue during the appeal process or the State Fair Hearing process. If you want to keep getting the same services, you must ask for your services to be continued in writing. If the result of the appeal or State Fair Hearing is not in your favor, you may have to pay for the services received during the appeal or State Fair Hearing process.

DO YOU HAVE A MEDICARE PART D PLAN?

Every **Medicare Part D** plan must have an exception and appeal process. If you have Medicare Part D Prescription Drug coverage and you file an exception or appeal, you may be able to get a prescription drug that is not normally covered by your Part D plan. Contact your Part D plan for help in filing an exception or appeal regarding your prescription drug coverage.

APPEALS FOR PERSONS DETERMINED TO HAVE A SERIOUS MENTAL ILLNESS (SMI)

Persons determined to have an SMI may appeal the following:

- A decision regarding fees or waivers;
- The denial, reduction, suspension or termination of any covered service;
- Capacity to make decisions, need for guardianship or other protective services or need for special assistance;
- A decision is made that the person is no longer eligible for SMI services; and
- A PASRR determination in the context of either a preadmission screening or an annual resident review, which adversely affects the person.

If you file an appeal, you will get written notice that your appeal was received within 5 business days of Arizona Complete Health-Complete Care Plan receipt. For an appeal that needs to be expedited, you will get written notice that your appeal was received within 1 business day of Arizona Complete Health-Complete Care Plan's receipt, and the informal conference must occur within 2 business days of filing the appeal.

Arizona Complete Health-Complete Care Plan will acknowledge and make a decision about your appeal just like we do other types of appeals. However, you will also have the right to meet with us face to face to discuss your appeal. You will have an informal conference with Arizona Complete Health-Complete Care Plan within 7 working days of filing the appeal. The informal conference must happen at a time and place that is convenient for you. You have the right to have a designated representative of your choice assist you at the conference. You and any other participants will be informed of the time and location of the conference in writing at least two days before the conference. If you are unable to come to the conference in person, you can participate in the conference over the telephone.

If there is no resolution of the appeal during this informal conference, and if the appeal does not relate to your eligibility for behavioral health services, the next step is a second informal conference with AHCCCS. This second informal conference must take place within 15 days of filing the appeal. If the appeal needs to be expedited, the second informal conference must take place within 2 working days of filing the appeal. You have the right to skip this second informal conference.

APPEALS OF
SERIOUS MENTAL ILLNESS (SMI) DETERMINATIONS

Persons asking for a determination of Serious Mental Illness (SMI) and persons who have been determined to have a SMI can appeal the result of a SMI determination.

If you request a SMI Determination, the decision will be made by Crisis Response Network. Crisis Response Network (CRN) is a statewide provider that that performs Serious Mental Illness (SMI) determinations.

If you or your provider requests an SMI determination, CRN will send you a letter by mail to let you know the final decision on your SMI determination. This letter is called a Notice of Decision. If CRN finds that you are not eligible for an SMI determination, the letter will tell you why. If you do not get the letter/notice by the end of the time you agreed to, please call CRN at 855-832-2866.

You have a right to appeal your SMI determination.

To appeal, you must contact CRN at 855-832-2866. CRN will provide you a letter that will include information on your member rights and how to appeal the SMI determination.

For more information, please contact:

Crisis Response Network (CRN)
1275 West Washington Street
Suite 108
Tempe, AZ 85281
855-832-2866

Changing Your Physical Health Services Plan For Members Determined to Have a Serious Mental Illness

Members who are determined to have a Serious Mental Illness (SMI) and who are enrolled in one plan for both physical health and behavioral health services may request a different plan for their physical health services. This is called an opt-out process. A member can only request to opt- out for certain reasons. To ask for an opt-out, the member must show harm or unfair treatment in:

1. Getting healthcare,
2. Receiving quality healthcare,
3. Protecting member privacy and rights, or
4. Choosing a provider.

If you would like to ask for an opt-out, contact member services at 1-888-788-4408, TTY/TDY 711.

Before you are moved to another AHCCCS health care plan, Arizona Complete Health-Complete Care Plan will try to resolve your concerns. If Arizona Complete Health-Complete Care Plan is not able to resolve your concerns, you or your designated representative may apply for a change in your health plan by contacting Member Services at 1-888-788-4408, TTY/TDY 711.

If you are requesting a change because you have been discriminated against, unfairly treated, or you believe that there is a possibility that discrimination or unfair treatment could occur, you will be asked to show proof. Simply being enrolled in an integrated health plan does not prove actual or potential discrimination or unfair treatment.

Arizona Complete Health-Complete Care Plan's review process will follow these steps:

1. Arizona Complete Health-Complete Care Plan will confirm that you are enrolled in the integrated plan;
2. Arizona Complete Health-Complete Care Plan Member Service's representative will record your claims of actual harm or possible discrimination or unfair treatment caused by enrollment in the integrated health plan.
3. Arizona Complete Health-Complete Care Plan Member Service's representative will complete the "Transfer of a SMI member enrolled in an RBHA to an AHCCCS Acute Care Contractor" form and include any evidence that you or your representative provide.

You will be provided the approval or denial in writing within ten (10) days of your request. If your request is approved, Arizona Complete Health-Complete Care Plan will work with your new AHCCCS health care plan to ensure there are no interruptions in your care. If your request is denied, you will be provided with the reasons for the denial and you will be informed of your right to make an appeal.

Member Rights

Our goal is to provide high-quality medical and behavioral health care. We also promise to listen, treat you with respect, and understand your individual needs. Members have rights and responsibilities. The following is a description of your rights as a Arizona Complete Health-Complete Care Plan member.

As a member, you have the right to:

- File a complaint about the managed care organization (Arizona Complete Health-Complete Care Plan). Please call us at Member Services if you have any issues with your care.
- Request information on the structure and operation of Arizona Complete Health-Complete Care Plan or our subcontractors
- Request information on whether Arizona Complete Health-Complete Care Plan has physician incentive plans (PIP) that affect the use of our referral services
- Know the types of compensation arrangements Arizona Complete Health-Complete Care Plan uses
- Know whether stop-loss insurance is required
- Receive a summary of member survey results
- The members' right to be treated fairly regardless of race, ethnicity, national origin, religion, gender, age, age, behavioral health condition (intellectual) or physical disability, sexual preference, genetic information, or ability to pay.
- A second opinion for a qualified health professional within the network, or have a second opinion arranged outside the network, only if there is not adequate in-network coverage at no cost to the enrollee
- Receive information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand the information
- Be provided with information about formulating advance directives with your health care providers.
- Request and receive annually, at no cost, a copy of your medical records. We must reply to your request for medical records within thirty (30) days. This response will either be a copy of your records, or a reason for denying your request. If a request is denied, in whole or in part, we must give you a written denial within sixty (60) days that includes the reason for the denial, your rights to disagree, and your rights to include your amendment with any future disclosures of your health information as allowed by law. Your right to access medical records may also be denied if the information is psychotherapy notes, compiled for, or in a reasonable anticipation of a civil, criminal or

administrative action, protected health information subject to Federal Clinical Laboratory Improvement Amendments of 1988 or exempt pursuant to 42 CFR Part 164.

- Amend or correct your medical records as allowed by law
- Be free from any restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- Receive information on beneficiary and plan information
- Be treated with respect, and recognition of your dignity and right to privacy. We understand your need for privacy and confidentiality, including protection of any information that identifies you
- Participate in decision-making regarding your health care, including the right to refuse treatment from a provider and have a representative facilitate care or treatment decisions when you are unable to do so
- Have a list of available providers as part of Arizona Complete Health-Complete Care Plan's Provider Directory, including those who speak a language other than English and are able to accommodate members with disabilities
- Use any hospital or other setting for emergency care without approval
- Select a primary care physician (PCP) from Arizona Complete Health-Complete Care Plan's participating PCPs
- For members in a HCBS or a behavioral health residential setting that have completed an Advance Directive, the document must be kept confidential but be readily available. For example: in a sealed envelope attached to the refrigerator
- Any restrictions on your freedom of choice among network providers
- Receive information in a language and format that you understand
- Be provided with information regarding grievance, appeals and request for hearing
- Have access to review medical records in accordance with applicable federal and state laws
- Request a copy of the Notice of Privacy Practices at no cost to you. The notice describes Arizona Complete Health-Complete Care Plan's privacy practices and how we use health information about you and when we may share that health information with others. Your health care information will be kept private and confidential. It will be given out only with your permission or if the law allows it.
- Respect and Dignity
  - Get your services in a safe environment;
  - You can get behavioral and medical services that support your personal beliefs, medical condition, and background in a language you understand
- Treatment Decisions

- Receive information on treatment options and alternatives, appropriate to your condition, in a way that you are able to understand and allows you to participate in decisions about your health care;
- Decide who you want with you during treatment and agree to or refuse treatment services, unless the services are court ordered;

- The member has the right to exercise his or her rights and that the exervice of those rights shall not adversely affect service deliver to the member [42 CFR 438.100(c)].

Health Care Privacy (Confidentiality)

There are laws about who can see your personal health information with or without your permission. Substance abuse treatment and communicable disease information (for example, HIV/AIDS information) cannot be shared with others without your written permission.

To help arrange and pay for your care, there are times when your information is shared without first getting your written permission. These times could include the sharing of information with:

- Physicians and other agencies providing health, social, or welfare services;
- Your medical primary care provider;
- Certain state agencies and schools following the law, involved in your care and treatment, as needed; and
- Members of the clinical team involved in your care.

At other times, it may be helpful to share your personal health information with other agencies, such as schools. Your written permission may be required before your information is shared.

There may be times that you want to share your health information with other agencies or certain individuals who may be assisting you. In these cases, you can sign an Authorization for the Release of Information Form, which states that your medical records, or certain limited portions of your medical records, may be released to the individuals or agencies that you name on the form. For more information about the Authorization for the Release of Information Form, contact Arizona Complete Health-Complete Care Plan at 1-888-788-4408, TTY/TDY 711 or go to our website at azcompletehealth.com/completecare

You can ask to see the health information in your medical record. You can also ask that the record be changed if you do not agree with its contents. You can also receive one copy per year of your medical record at no cost to you. Contact your provider or Arizona Complete Health-Complete Care Plan to ask to see or get a copy of your medical record. Arizona Complete

Health-Complete Care Plan Member Services can help you. Just call 1-888-788-4408, TTY/TDY 711 to request a copy**.** You will receive a response to your request within 30 days. If you receive a written denial to your request, you will be provided with information about why your request to obtain your medical record was denied and how you can seek a review of that denial.

Arizona Complete Health-Complete Care Plan has a Notice of Privacy Practices (NPP) available at any time. You can access this NPP by visiting the Arizona Complete Health-Complete Care Plan website, or calling customer service at 1-888-788-4408, TTY/TDY 711 to request a copy.

EXCEPTIONS TO CONFIDENTIALITY

There are times when we cannot keep information confidential. The following information is not protected by the law:

- If you commit a crime or threaten to commit a crime at the program or against any person who works at the program, we must call the police.
- If you are going to hurt another person, we must let that person know so that they can protect themselves. We must also call the police.
- We must also report suspected child abuse to local authorities.
- If there is a danger that you might hurt yourself, we must try to protect you. If this happens, we may need to talk to other people in your life or other service providers (e.g., hospitals and other counselors) to protect you. Only necessary information to keep you safe is shared.

Coordination of Care With Schools and State Agencies

With your written consent, coordination of care may take place with other types of programs and services such as the Department of Economic Security, Division of Development Disabilities, Rehabilitative Services Administration, Administrative Office of the Courts/Juvenile Probation, Arizona Department of Corrections, Arizona Department of Juvenile Corrections, Administrative Office of the Courts, and the Department of Education as well as local schools and other local health departments or community service agencies when applicable.

What is Fraud and Abuse?

Fraud is any lie told on purpose that results in you or some other person receiving unnecessary benefits. This includes any act of fraud defined by Federal or State law.

Examples of Member Fraud include but are not limited to:

- Lending or selling your AHCCCS Identification Card to anyone.
- Changing prescriptions written by any of our providers.
- Selling prescription drugs.
- Giving incorrect information on your AHCCCS application.

Examples of Provider Fraud include but are not limited to:

- Use of the Medicaid system by someone who is inappropriate, unqualified, unlicensed or has lost their license.
- Providing unnecessary medical services.
- Not meeting professional standards for health care.
- Billing for appointments that do not happen.

Abuse describes practices that, either directly or indirectly, result in unnecessary costs. Abuse includes but is not limited to the following:

Abuse by a Member consists of unnecessary costs to the program as a result of:

- Providing false materials or documents
- Leaving out important information

Abuse by a Provider consists of actions that are not wise business or medical practices and result in:

- Unnecessary costs to the program
- Payment for services that are not medically necessary
- Not meeting professional standards for health care
- Charging excessively for services or supplies.

HOW TO REPORT FRAUD AND ABUSE:

If you suspect one of our providers or members of fraud and abuse, please contact Arizona Complete Health-Complete Care Plan at 1-888-788-4408 or TTY/TDY 711.

You may also report Fraud and Abuse to AHCCCS at 1-602-417-4000 or toll free at 1-800-654-8713

Penalties: A person who is suspected of fraud and/or abuse of the AHCCCS system will be reported to AHCCCS. Penalties for people involved in fraud and/or abuse may be both civil and criminal.

Community Resources

TOBACCO EDUCATION AND PREVENTION

If you are thinking about quitting smoking, we can help you do this. You can enroll in a program to help you stop smoking through the Arizona Department of Health Services (ADHS).

- You can get free coaching from the Arizona Smokers' Helpline (ASHLine) at 1-800-556-6222.
- You can go online at www.ashline.org.
- You can get help making a plan to quit at https://www.azdhs.gov/preparedness/epidemiology-disease-control/smoke-free-arizona/index.php

Your plan covers many kinds of products to help you quit. These include prescription drugs and OTCs (over the counter). You must contact your Primary Care Provider (PCP) for any of these products, including OTCs. Your doctor will decide which one would be best for you. If you are under 18 years old, your doctor will need to get prior authorization (PA) for the drug you need. Your doctor will take care of this for you. Your plan covers up to a twelve week supply in a six month time period. The six month time period starts the date that you first get your drug from the pharmacy.

ALZHEIMER'S ASSOCIATION

The Alzheimer's Association provides education and resources to those affected by Alzheimer's disease.
Phone: (800) 272-3900
Website: www.alz.org

ARIZONA WOMEN INFANTS AND CHILDREN (WIC)

WIC provides food, breastfeeding education, and information on healthy diet to women who are pregnant, infants, and children under five years old.
150 N. 18th Ave., Ste. 310, Phoenix, AZ 85007
Phone: 1-800-252-5942
Website: www.azdhs.gov/azwic/

AZ SUICIDE PREVENTION COALITION

Arizona Suicide Prevention Coalition works to reduce suicidal acts in Arizona. Their mission is to change those conditions that result in suicidal acts in Arizona through awareness, intervention and action.
PO Box 10745
Phoenix, AZ 85064
Website: www.azspc.org

HEALTH-E-ARIZONA PLUS

AHCCCS and DES collaborated to develop a system to apply for AHCCCS Health Insurance, KidsCare, Nutrition Assistance and Cash Assistance benefits and to connect to the Federal Insurance Marketplace.

Website: www.healthearizonaplus.gov

AZLINKS.GOV

AzLinks.gov offers assistance and information on aging and disability. Use AzLinks.gov to plan for the future or handle an immediate need. Our Az Links partner agencies in your community are there to help.
Website: www.AzLinks.gov

HEALTHY FAMILIES ARIZONA

This program helps child-bearers have a healthy pregnancy and helps with child development, nutrition, safety and other things. A community health worker will go to the pregnant member's home to give her information and help with any concerns that she might have. The program starts while the member is pregnant, and can continue through the time that the baby is 5 years old.

1789 W. Jefferson St., Phoenix, AZ 85007
Phone: 602‑542‑4791
Website: https://des.az.gov/services

PIMA COUNCIL ON AGING

Pima Council on Aging advocates, plans, coordinates, develops and delivers home-and-community based aging services for older adults and provides support assistance, accurate information, and local resources connections for family caregivers.

8467 East Broadway Blvd.
Tucson, AZ 85710
Phone: (520) 790-7262
Website: https://www.pcoa.org/

ARIZONA EARLY INTERVENTION PROGRAM (AZEIP)

The Arizona Early Intervention Program (AzEIP, pronounced Ay‑zip), helps families of children with disabilities or developmental delays age birth to three years old. They provide support and can work with their natural ability to learn. To get help or learn more about AzEIP resources, call Arizona Complete Health-Complete Care Plan and ask for the Arizona Complete Health-Complete Care Plan AzEIP coordinator.
Phone: 602‑532‑9960

Website: www.azdes.gov/AzEIP

ARIZONA HEAD START

Head Start is a great program that gets preschoolers ready for kindergarten. Preschoolers enrolled in Head Start will get healthy snacks and meals too. Head Start offers these services and more at no cost to you.

Website: www.azheadstart.org

NAMI ARIZONA (NATIONAL ALLIANCE ON MENTAL ILLNESS)

NAMI Arizona has a HelpLine for information on mental illness, referrals to treatment and community services, and information on local consumer and family self-help groups throughout Arizona. NAMI Arizona provides emotional support, education, and advocacy to people of all ages who are affected by mental illness.

Phone: 480-994-4407

Website: http://www.namiarizona.org/

AzDHS Dump the Drugs AZ

App providing information on where to dispose of medications. Locate and get directions to the nearest site to safely dispose of unwanted prescription drugs.

https://azdhs.gov/gis/dump-the-drugs-az/

MENTALLY ILL KIDS IN DISTRESS (MIKID)

MIKID provides support and help to families in Arizona with behaviorally challenged children, youth, and young adults. MIKID offers information on children's issues, internet access for parents, referrals to resources, support groups, educational speakers, holiday and birthday support for children in out of home placement, and parent-to-parent volunteer mentors.

Phone: 520-882-0142 (Pima);

928-344-1983 (Yuma)

Website: http://www.mikid.org/

COMMUNITY INFORMATION AND REFERRAL

Community Information and Referral is a call center that can help you find many community services.

Food banks, clothes, shelters, help to pay rent and utilities Health care, pregnancy health, help when you or someone else is in trouble, support groups, counseling, and help with drug or alcohol problems

Financial help, job training, transportation, education programs Adult day care, meals on wheels, respite care, home health care, transportation, homemaker services Childcare, after school programs, family help, summer camps and play programs, counseling, help with learning, protective services
Phone: 2-1-1
Website: www.cir.org

CHILD AND FAMILY RESOURCES
Child and Family Resources Programs include:

Child Care Resource & Referral, where parents call to get a list of child care centers

The Center for Adolescent Parents where teens who have had a child can earn their high school diploma or GED while receiving no cost, onsite childcare

Child & Family Resources Headquarters
Angel Charity Building
2800 E. Broadway Blvd.
Tucson, AZ 85716
(520) 881-8940

Douglas
1065 F Avenue #4
Douglas, AZ 86426
(520) 364-5014

Safford
1491 W. Thatcher Boulevard
Suite 106
Safford, AZ 85546
(928) 428-7231

Sierra Vista
3965 E. Foothills Drive
Suite E1
Sierra Vista, AZ 85635
(520) 458-7348

Casa Grande Office
1115 E. Florence Boulevard
Suite M
Casa Grande, AZ 85122
(520) 518-5292

Nogales
1827 N. Mastick Way
Nogales, AZ 85621
(520) 281-9303

Yuma
201 S. 3rd Ave.
Yuma, AZ 85364
(928) 783-4003
(800) 929-8194

www.childfamilyresources.org

Low Cost/Sliding Scale Health Care Providers

If you become ineligible for Medicaid and are not able to get other health insurance, you can visit this website to look for clinics that provide free or low cost primary, mental, and dental health services to people without health insurance.

https://www.azdhs.gov/prevention/health-systems-development/sliding-fee-schedule/index.php#clinic-locations

Advocacy Information

A healthcare advocate is someone who works to promote and protect people's rights in the healthcare system. Arizona Complete Health-Complete Care Plan partners with advocates across Southern and Central Arizona to ensure your rights are upheld and your voice is heard. Our advocacy team can help you through an appeal process on grievances, mediate problems with your health care provider, and connect with advocacy organizations.

Some advocacy organizations that Arizona Complete Health-Complete Care Plan partners with are as follows:

Arizona Center for Disability Law – Mental Health
The Arizona Center for Disability Law is dedicated to protecting the rights of individuals with physical, mental, psychiatric, sensory and cognitive disabilities. You can contact them at (800) 922-1447 for more information.

National Alliance on Mental Illness
NAMI, the National Alliance on Mental Illness, is the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness. To learn more about their organization and advocacy programs call them at 1-800-950-NAMI.

Arizona Coalition Against Sexual and Domestic Violence
The Arizona Coalition Against Sexual and Domestic Violence serve providers of direct services to victims and survivors of sexual and domestic violence. Their purpose is:

- Increase public awareness about the issues of sexual and domestic violence
- Enhance the safety of and services for sexual and domestic violence victims and survivors
- End sexual and domestic violence in Arizona communities

If you need help, please call the National Domestic Violence Hotline: 1-800-799-7233 (SAFE) or TTY 1-800-787-3224.

Arizona Child and Family Advocacy Network

The Arizona Child and Family Advocacy Network (ACFAN) provides support, training and guidance to all advocacy centers in Arizona and their professionals who coordinate services and respond to family violence and sexual assault. Efforts are made to accommodate special needs and multilingual populations.

ACFAN has Advocacy centers located throughout Arizona that are designed to provide onsite services to child victims of either physical or sexual abuse as well as neglect. Some centers provide services to adult victims of sexual assault, domestic violence, or vulnerable adult abuse. For more information on these advocacy centers, you can visit their website at http://acfan.net/ or call them at 1-928-750-3583.

Family Advocacy Center Services

The Family Advocacy Center (FAC) services include, but are not limited to:

- Crisis intervention
- Emergency needs assessment
- Safety planning
- 9-1-1 Phone
- Shelter access and emergency housing assistance
- Victim's rights education
- Current case status updates
- Referrals for long-term case management
- Short-term case management
- Education on domestic violence dynamics
- Education learning how to navigate the criminal justice system

You can contact a FAC victim advocate to obtain help with services at 1-602-534-2120 or 1-888-246-0303.

Terms & Definitions

Appeal: To ask for review of a decision that denies or limits a service.

Copayment: Money a member is asked to pay for a covered health service, when the service is given.

Durable Medical Equipment: Equipment and supplies ordered by a health care provider for a medical reason for repeated use.

Emergency Medical Condition: An illness, injury, symptom or condition (including severe pain) that a reasonable person could expect that not getting medical attention right away would:

- Put the person's health in danger; or
- Put a pregnant individual's baby in danger; or
- Cause serious damage to bodily functions; or
- Cause serious damage to any body organ or body part.

Emergency Medical Transportation: See EMERGENCY AMBULANCE SERVICES

Emergency Ambulance Services: **Transportation by an ambulance for an emergency condition.**

Emergency Room Care: Care you get in an emergency room.

Emergency Services: Services to treat an emergency condition.

Excluded Services: See EXCLUDED

Excluded: Services that AHCCCS does not cover. Examples are services that are:

- Above a limit,
- Experimental, or
- Not medically needed.

Grievance: A complaint that the member communicates to their health plan. It does not include a complaint for a health plan's decision to deny or limit a request for services.

Habilitation Services and Devices: See HABILITATION

Habilitation: Services that help a person get and keep skills and functioning for daily living.

Health Insurance: Coverage of costs for health care services.

Home Health Care: See HOME HEALTH SERVICES

Home Health Services: Nursing, home health aide, and therapy services; and medical supplies, equipment, and appliances a member receives at home based on a doctor's order.

Hospice Services: Comfort and support services for a member deemed by a Physician to be in the last stages (six months or less) of life.

Hospital Outpatient Care: Care in a hospital that usually does not require an overnight stay.

Hospitalization: Being admitted to or staying in a hospital.

Medically Necessary: A service given by a doctor, or licensed health practitioner that helps with health problem, stops disease, disability, or extends life.

Network: Physicians, health care providers, suppliers and hospitals that contract with a health plan to give care to members.

Non-Participating Provider: See OUT OF NETWORK PROVIDER

Out of Network Provider: A health care provider that has a provider agreement with AHCCCS but does not have a contract with your health plan. . You may be responsible for the cost of care for out-of-network providers.

Participating Provider: See IN-NETWORK PROVIDER

In-Network Provider: A health care provider that has a contract with your health plan.

Physician Services: Health care services given by a licensed physician.

Plan: See SERVICE PLAN

Service Plan: A written description of covered health services, and other supports which may include:

- Individual goals;
- Family support services;
- Care coordination; and
- Plans to help the member better their quality of life.

Preauthorization: See PRIOR AUTHORIZATION

Prior Authorization: Approval from a health plan that may be required before you get a service. This is not a promise that the health plan will cover the cost of the service.
Premium: The monthly amount that a member pays for health insurance. A member may have other costs for care including a deductible, copayments, and coinsurance.

Prescription Drug Coverage: Prescription drugs and medications paid for by your health plan.

Prescription Drugs: Medications ordered by a health care professional and given by a pharmacist.

Primary Care Physician: A doctor who is responsible for managing and treating the member's health.

Primary Care Provider (PCP): A person who is responsible for the management of the member's health care. A PCP may be a:

- Person licensed as an allopathic or osteopathic physician, or
- Practitioner defined as a physician assistant licensed or
- Certified nurse practitioner.

Provider: A person or group who has an agreement with AHCCCS to provide services to AHCCCS members.

Rehabilitation Services and Devices: See REHABILITATION

Rehabilitation: Services that help a person restore and keep skills and functioning for daily living that have been lost or impaired.

Skilled Nursing Care: Skilled services provided in your home or in a nursing home by licensed nurses or therapists.

Specialist: A doctor who practices a specific area of medicine or focuses on a group of patients.

Urgent Care: Care for an illness, injury, or condition serious enough to seek immediate care, but not serious enough to require emergency room care.

Maternity Care Service Definitions

Certified Nurse Midwife (CNM) is certified by the American College of Nursing Midwives (ACNM) on the basis of a national certification examination and licensed to practice in Arizona by the State Board of Nursing. CNMs practice independent management of care for pregnant individuals and newborns, providing antepartum, intrapartum, postpartum, gynecological, and

newborn care, within a health care system that provides for medical consultation, collaborative management, or referral management or referral.

High‑risk pregnancy refers to a pregnancy in which the child-bearer, fetus, or newborn is, or is anticipated to be, at increased risk for morbidity or mortality before or after delivery. High risk is determined using the Medical Insurance Company of Arizona (MICA) or American College of Obstetricians and Gynecologists (ACOG) standardized medical risk assessment tools.

Licensed Midwife is an individual licensed by the Arizona Department of Health Services to provide maternity care pursuant to Arizona Revised Statutes (A.R.S.) Title 36, Chapter 6, Article 7 and Arizona Administrative Code Title 9, Chapter 16 (This provider type does not include certified nurse midwives licensed by the Board of Nursing as a nurse practitioner in midwifery or physician assistants licensed by the Arizona Medical Board).

Maternity care includes identification of pregnancy, prenatal care, labor/delivery services, and postpartum care.

Maternity care coordination consists of the following maternity care related activities: determining the member's medical or social needs through a risk assessment evaluation; developing a plan of care designed to address those needs; coordinating referrals of the member to appropriate service providers and community resources; monitoring referrals to ensure the services are received; and revising the plan of care, as appropriate.

Practitioner refers to certified nurse practitioners in midwifery, physician's assistants, and other nurse practitioners. Physician's assistants and nurse practitioners are defined in A.R.S. Title 32, Chapters 25 and 15 respectively.

Postpartum care is the health care provided for a period of up to 60 days post‑ delivery. Family planning services are included if provided by a physician or practitioner.

Preconception counseling services, as part of an annualvisit, are provided when medically necessary. This counseling focuses on the early detection and management of risk factors before pregnancy, and includes efforts to influence behaviors that can affect a fetus (even before conception is confirmed), as well as regular health care. The purpose of preconception counseling is to ensure that an individualis healthy prior to pregnancy. Preconception counseling does not include genetic testing.

Prenatal care is the health care provided during pregnancy and is composed of three major components:

- Early and continuous risk assessment
- Health education and promotion

- Medical monitoring, intervention, and follow-up

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 07.01.2017

For help to translate or understand this, please call 1-888-788-4408 (TTY 711.)

Si necesita ayuda para traducir o entender este texto, por favor llame al telefono.

1-888-788-4408 (TTY 711).

Interpreter services are provided free of charge to you.

Covered Entities Duties:

Arizona Complete Health is a Covered Entity as defined and regulated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Arizona Complete Health 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.

Arizona Complete Health 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. Arizona Complete Health 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 the Arizona Complete Health Arizona website, located below.

https://review-www.azcompletehealth.com/privacy-practices.html

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 health care 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 health care services provided to you. We may disclose your PHI to another health plan, to a health care provider, or other entity subject to the federal Privacy Rules for their payment purposes. Payment activities may include
  - processing claims
  - determining eligibility or coverage for claims
  - issuing premium billings
  - reviewing services for medical necessity
  - performing utilization review of claims
- ***HealthCare Operations*** - We may use and disclose your PHI to perform our healthcare operations. These activities may include:
  - providing customer services
  - responding to complaints and appeals
  - providing case management and care coordination
  - conducting medical review of claims and other quality assessment
  - improvement activities

  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

- case management and care coordination
- detecting or preventing healthcare fraud and abuse.

- ***Group Health Plan/Plan Sponsor Disclosures*** – We may disclose your protected health information to a sponsor of the group health plan, such as an employer or other entity that is providing a health care program to you, if the sponsor has agreed to certain restrictions on how it will use or disclose the protected health information (such as agreeing not to use the protected health information for employment-related actions or decisions).

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 disclosure 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.
- ***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 disclosure your PHI to the Food and Drug Administration (FDA) to ensure the quality, safety or effectiveness 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 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 judicial and administrative proceedings. We may also disclose it in response to the following:

    - an order of a court
    - administrative tribunal
    - subpoena
    - summons
    - warrant
    - discovery request
    - similar legal request.

- ***Law Enforcement*** - We may disclose your relevant PHI to law enforcement when required to do so. For example, in response to a:
-
    - court order
    - court-ordered warrant
    - subpoena
    - summons issued by a judicial officer
    - grand jury subpoena

  We may also disclose your relevant PHI to identify or locate a suspect, fugitive, material witness, or missing person.

- ***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*** - 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
    - 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
    - to intelligence activities
    - the Department of State for medical suitability determinations
    - for protective services of the President or other authorized persons
- ***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 previous identified by you. We will use professional judgment and experience to determine if the disclosure is in your best interests. 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 purposed 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 you psychotherapy notes that we may have on file with limited exception, such as for certain treatment, payment or healthcare operation functions.

INDIVIDUALS 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 Revoke an Authorization*** - You may revoke your authorization at any time, the revocation of your authorization must be in writing. The revocation will be effective immediately, except to the extent that we have already taken actions in reliance of the authorization and before we received your written revocation.
- ***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 restriction applies. 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 is 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 you PHI should be delivered.

- ***Right to Access and Received 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 and 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 years 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: 1-866-788-4989) 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 list 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.

CONTACT INFORMATION

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.

Arizona Complete Health

Attn: Privacy Official

1870 E. Rio Salado Parkway

Tempe, AZ 85281

1-866-475-3129