Health Net Access

Member *Handbook*

A helpful guide to getting services
(Combined Evidence of Coverage and Disclosure Form)

Benefit Year 2018
Revised on October 1, 2017

Health Net Access™

Covered services are funded under contract with AHCCCS

TABLE OF CONTENTS

DISCRIMINATION IS AGAINST THE LAW

Health Net Access (HNA) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. HNA does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

HNA:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages

If you need these services, contact:

HNA Member Services at 1-888-788-4408 (TTY 711)

If you believe that HNA 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. You can file a grievance in person or 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: HNA Chief Compliance Officer 1230 W. Washington Street Suite 401 Phoenix, AZ 85281. Fax: 866.388.2247 Email: chross@centene.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, 800-537-7697 (TDD).

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

LA DISCRIMINACIÓN ES CONTRA LA LEY

Health Net Access (HNA) 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. HNA no excluye a las personas ni las trata en forma distinta debido a su raza, color, nacionalidad, edad, discapacidad o sexo.

HNA:

- 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, comuníquese con:

Servicios a los Afiliados de HNA al 1-888-788-4408 (TTY 711)

Si considera que HNA 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). 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: HNA Chief Compliance Officer, 1230 W. Washington Street Suite 401 Phoenix, AZ 85281. Fax: 866.388.2247, correo electrónico: chross@centene.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, 800-537-7697 (TDD).

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

LANGUAGE SERVICES

English- ATTENTION: If you speak a language other than English, language assistance services are available to you at no cost. To communicate with us call 888-788-4408 (TTY 711).
Español (Spanish) - ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame 888-788-4408 (TTY 711).
Diné Bizaad (Navajo) - Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee aká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 888-788-4408 (TTY 711).
繁體中文 **(Chinese)** - 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 888-788-4408 (TTY 711).
Tiếng Việt (Vietnamese) - CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 888-788-4408 (TTY 711).
العربية (Arabic) - ملحوظة: إذا كنت تتحدث لغة غير الإنجليزية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 888-788-4408 (رقم هاتف الصم والبكم: 711 TTY).
Tagalog- PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 888-788-4408 (TTY 711).
한국어 (Korean) - 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 888-788-4408 (TTY 711) 번으로 전화해 주십시오.
Français (French) - ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 888-788-4408 (TTY 711).
Deutsch (German) - ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 888-788-4408 (TTY 711).
Русский (Russian) - ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 888-788-4408 (TTY 711).
日本語 **(Japanese)** - **注意事項**：**日本語を話される場合、無料の言語支援をご利用いただけます。**888-788-4408 (TTY 711) **まで、お電話にてご連絡ください。**
فارسي (Persian) -**توجه**: اگر به زباني به غير از انگليسي گفتگو مي كنيد، خدمات تسهيلات زباني بصورت رايگان براي شما فراهم مي باشد. براي ارتباط با ما با شماره تلفن 888-788-4408 (TTY 711: براي كساني كه مشكل شنوايي دارند) تماس بگيريد.
ܣܘܪܝܝܐ (Assyrian) - للعلم مع التحية: ان لن بريومت همزوت انكلش أختي ماصخ مساعدة .اختي لا شقلخ زوزة .يمصت تلفون دوا رقم 888-788-4408 (TYY 711).
Srpsko-hrvatski (Serbo-Croatian) - OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 888-788-4408 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).
ภาษาไทย (Thai) - เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 888-788-4408 (TTY 711).

MEMBER SERVICES DEPARTMENT

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/TDD: 711), or if you are a TTY user you can contact the Arizona Relay System at 1-800-367-8939. If you speak another language other than English, call Member Services and we will help get an interpreter to assist with the phone call.

PROTECTING YOUR HEALTH INFORMATION: MEMBER VERIFICATION

When you call Member Services, you will be asked questions to verify your account. We do this for your protection and are required to do so by law. This is how we make sure we do not share your information with the wrong person.

You will be asked to verify the following information: AHCCCS ID number, birth date, address, and phone number.

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 a Case Manager to make sure you are getting the care you need.

In this handbook, we use "you" and "your" to mean "the AHCCCS member." We use "we," "us," "our" and "our plan" to mean "Health Net Access." Only the member can get the benefits talked about in this handbook.

EMERGENCY CARE/ URGENT CARE (AFTER HOURS CARE)

After-Hours Care (Urgent Care)

An Urgent Care Center is a great place to get medical help because they usually have extended hours (after hours), doctors to treat common problems, and can see you quickly. 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.

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

If you feel your symptom is an emergency, call 911. 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 Health Net Access member and show your Health Net Access 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.

BEHAVIORAL HEALTH EMERGENCIES

If you have a behavioral health emergency, it is important to get help right away. Call the Maricopa County 24-Hour Crisis Line at 1-602-222-9444 or 1-800-631-1314 (TTY/TDD: 1-602-274-3360) or Health Net Access at 1-888-788-4408 (TTY/TDD: 711). You should call 911 if you are having a life-threatening medical or behavioral health emergency or if you are going to hurt yourself or someone else.

CULTURAL COMPETENCY

We value you. We understand that there are many diverse cultural and ethnic backgrounds of people in Maricopa County. 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 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, please contact Member Services. Sign Language interpreters are available at no cost to you. We can schedule an interpreter to help with your appointment. **If you need language assistance or any of our printed materials translated into another language, including Braille, please call Member Services.** Call us and let us know if we have overlooked anything that is important to you. We will try 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. 1-888-788-4408 (TTY/TDD: 711).

HELP IN ANOTHER LANGUAGE AND FOR THE DISABLED: HOW CAN I GET HELP?

If you need this handbook or other health information in another language or in an alternative format such as large font, audio or accessible pdf, or Braille please contact Member Services at 1-888-788-4408 or TTY/TDD: 711. 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.

Si necesita este manual u otro tipo de información sobre salud traducido a otro idioma o en un formato diferente (como letra grande, audio o PDF accesible), comuníquese con el Departamento de Servicios al Afiliado al 1-888-788-4408 o a la línea TTY/TDD 711. Además, si necesita servicios de interpretación, comuníquese con el Departamento de Servicios al Afiliado al menos cinco (5) días antes de su cita médica para coordinar los servicios de interpretación de idiomas; así podrá disponer de ellos en sus citas médicas. Los servicios de interpretación de idiomas no tienen costo alguno para usted. No es necesario que recurra a un familiar o a un amigo para que cumplan el rol de intérpretes.

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.

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).

PRINTED INFORMATION FOR VISUALLY IMPAIRED MEMBERS

If you have a visual impairment and you require this member handbook or other materials, such as notices and consent forms, to be printed in large print or Braille, contact your provider or Health Net Access Member Services at 1-888-788-4408 (TTY/TDD: 711) to receive your materials in an alternative format.

Health Net Access 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 Member Services. You will need to contact the provider to make, change, or cancel your appointments. You may also contact Health Net Access if you would like assistance with making, changing, or canceling your appointments.

If you are not happy with your current provider, contact Health Net Access Member Services to discuss other available options.

PROVIDER DIRECTORY

A Provider Directory is available online. Visit www.healthnetaccess.com to use our "Provider Search" tool or to download a copy of the directory. Included in the directory and the online search tool are primary care physicians, specialists, OB/GYNs, hospitals and more. **You may request a copy be mailed at no charge to you by calling Member Services** at 1-888-788-4408 (TTY/TDD: 711). The provider directory is available in English and Spanish.

USING THE HEALTH PLAN

Health Net Access is a Managed Care Plan that serves members in Maricopa County. A Managed Care Plan is a health plan that provides health care to its members through a selected group of doctors, hospitals, and pharmacies. You and your Primary Care Physician (PCP) play an important role in your Managed Care Plan. Your PCP helps decide what care you need, so it is important you see your doctor and talk with him or her about your health. You need to have regular checkups every year. Regular screenings help keep you healthy.

Your responsibility as a member is to make sure you always follow these steps when you need health care:

1) Always carry and show your Health Net Access Identification (ID) Card.
2) Call your doctor's office for preventive care or if you have a medical problem.
3) Keep your medical appointments or call the office to reschedule if you are unable to keep an appointment.
4) Make sure you have a referral from your doctor when you need to see a specialist.
5) Cooperate with your doctor's instructions (However, you may refuse medical treatment).

YOUR PRIMARY CARE PROVIDER (PCP)

Your Primary Care Provider (PCP) is your assigned doctor and plays an important role in your health care. Your Primary Care Provider (PCP) is the "gatekeeper" for all services you receive. He or she will get to know you, your health needs and medical history. Your PCP will provide routine health care and arrange for any specialty care you may need. You must see your assigned PCP before you see any other doctor, unless you have an emergency or behavioral health problem.

Please note:

- Children under the age of 21 can visit a dentist without visiting their PCP first.

- Women 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.

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

Contact the Health Net Access Member Services Department (Member Services) with any questions or concerns about your health benefits or medical services.

IDENTIFICATION (ID) CARDS: HOW DO I USE THEM?

Once you are enrolled in our plan, you will receive a Health Net Access Identification (ID) card. Do not throw this card away. It is very important to carry this card with you at all times and show it when you receive medical services. This card will identify you as our member and lists important phone numbers and information that your health care provider will need.

Your ID card has a phone number to access behavioral health and substance abuse 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 the number on your card. Call Member Services to access behavioral health and substance abuse services.

You will need your Health Net Access ID card to:

- Make doctor appointments
- See your doctor
- Get medicine and supplies
- Get care from a hospital or other medical provider
- Get help and information from Member Services

To help protect your identity and prevent fraud, AHCCCS is adding pictures to its online verification tool that providers use to verify your coverage. If you have an Arizona driver's license or state issued ID, AHCCCS will get your picture from the Arizona Department of Transportation Motor Vehicle Division (MVD). When providers pull up the AHCCCS eligibility verification screen, they will see your picture (if available) with your coverage details.

Only you are allowed to use your Health Net Access ID card for health care 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.

If you don't have a Health Net Access ID card or if you lose your card, call Member Services at 1-888-788-4408 (TTY/TDD: 711) and we will mail you a new one.

MEMBER RESPONSIBILITIES

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
- Make contributions toward your own care
- 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
- Protecting your Health Net Access 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.

AHCCCS: HOW CAN I MAKE SURE I DON'T LOSE MY COVERAGE?

WHAT TO DO WHEN YOUR FAMILY SIZE CHANGES

If there is a change in the number of people in your family due to birth, death, marriage, adoption or divorce, you must call your Department of Economic Security (DES) office at 1-602-542-9935 or your Social Security office at 1-800-772-1213 to make sure all family members are covered by AHCCCS.

If you are a KidsCare member, please call the AHCCCS KidsCare Unit toll free at 1-877-764-5437 to report these changes.

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

IF YOU MOVE, YOU MUST TELL US!

As a member of our plan, your service area is Maricopa County. If you move out of the United States, the state of Arizona, or out of Maricopa County, 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.

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 Member Services if you have questions about your enrollment or call AHCCCS at 1-800-654-8713 or 1-602-417-4000.

Each new person in your family must be made eligible for AHCCCS. 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. If you have any questions, call Member Services. **You could lose your care with AHCCCS if you do not tell them you are moving.**

If you move to another county, what should you do?

- Tell your current eligibility office and re-apply at your new eligibility office.
- Call the AHCCCS office to choose a new plan if you are AHCCCS-eligible.
- Call your new plan and choose a provider.

Call Member Services if you have any questions about what to do or call AHCCCS at 1-800-654-8713.

RENEWING AHCCCS COVERAGE

AHCCCS members are required to renew their eligibility at least once every year. You will receive a letter when it is time to renew. The letter will tell you who to contact to renew your benefits and when your coverage ends. Please take the time to update your eligibility information and continue your AHCCCS coverage. Be sure to update your phone number and address as well. Your renewal will be processed by AHCCCS if you are enrolled in KidsCare. All other Health Net Access members should first contact the Department of Economic Security (DES) at 1-800-352-8401 or 1-602-542-9935 or their local Social Security Eligibility office at 1-800-772-1213 to renew coverage. You can call Member Services if you have questions or need assistance with the renewal process. We are happy to answer any questions you might have.

Your enrollment with us can end if you are no longer eligible for AHCCCS or KidsCare (Title XXI) or if you:

- Stop getting Temporary Assistance to Needy Families (TANF)
- Stop getting food stamps
- Did not renew your AHCCCS eligibility before your renewal deadline

If you don't know why you are no longer enrolled, call AHCCCS at 1-800-654-8713 or 1-602-417-4000. You can call Member Services to get your renewal date.

ANNUAL ENROLLMENT CHOICE (AEC)

You may change your health plan on your AHCCCS enrollment anniversary date every year. AHCCCS will send you information two months before your anniversary date. If you are thinking about leaving our plan, please call Member Services so we can help solve any problems you may have. We value your membership.

HEALTH PLAN CHANGES

There are certain reasons why you may change your health plan outside of your normal AEC period.

1. You were not given a choice of health plans.
2. You did not get your AEC letter.
3. You got your AEC letter but were not able to take part in your AEC due to events out of your control.
4. Other members in your family are enrolled with another health plan (unless you were given a choice during the AEC process and did not change).
5. You are a member of a special group and need to be enrolled in the same health plan as the special group.
6. You came back on AHCCCS within 90 days and were not put back on the health plan you had before.
7. You have a medical reason why you must stay with your current provider and he/she is not on our plan.

If you need to change your health plan due to any of the above reasons, please call AHCCCS at 1-800-654-8713 or 1-602-417-4000. You may also change your health plan for medical reasons. You may ask us to

change your health plan if you have a medical reason for changing it. We will review your request and let you know if you can change plans.

These are examples of medical reasons:

- You are pregnant and the doctor you see is not on our plan.
- You have a medical problem like cancer and the doctor you see is not on our plan.

If there is another reason why you must change your health plan, or you have questions about changing your health plan, please call Member Services.

TRANSITION OF CARE POLICY

We want to help you if you are moving and have a new AHCCCS plan.

Health Net Access will always help with coordination of care for all of our members during transitions between Managed Care Organizations, changes in service areas, and/or health care providers. Certain members may require additional help during a period of transition. If you have questions about coordination of care when making changes, please call our member services department.

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. Also, Health Net Access has a 24 hour Nurse Advice and Triage Line. If you have questions about a health problem or urgent medical problem, our Nurse Advice Line can help you. Call Member Services to be connected to the Nurse Advice Line.

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 Health Net Access ID so the doctors can notify us.

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.**

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

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 Health Net Access member and show your Health Net Access 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.

TRANSPORTATION: HOW DO I GET RIDES TO MEDICAL APPOINTMENTS?

EMERGENCY TRANSPORTATION

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

You do not need prior authorization for emergency services, including visits to the emergency room and emergency transportation.

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, 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.

CAR SEAT, WHEELCHAIR OR STRETCHER

If you need a car seat, 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.

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. Let the representative know if you do not have a car seat.

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.

WHAT IS COVERED: WHAT KIND OF HEALTH CARE CAN I GET FROM HEALTH NET ACCESS?

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

- A Covered Benefit with AHCCCS, and
- Medically Necessary

A "Covered Benefit" means that you can get this service through AHCCCS and Health Net Access. "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.

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.

COVERED SERVICES

Depending on your eligibility, Health Net Access must pay only for the available services listed. Call Member Services or talk to your PCP for more information about these services:

- Ambulance for emergency care
- Audiology services to evaluate hearing loss on both outpatient and inpatient basis
- Behavioral Health Care (please see the *"Behavioral Health Services"* section for more information)
- Care while you are pregnant
- Case management
- Checkups for children*, pregnant women 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)
- Hospice care
- Hospital care
- 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 Health Net Access 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*

MORE BENEFITS: WHAT OTHER SERVICES CAN I GET?

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

CASE MANAGEMENT

Case management is a benefit we offer at no cost to you. Our goal is to help you be healthy through education and your own health care planning. Our nurses will help you and/or a family member get the health care you need, understand your medicines, help you obtain names and numbers for community resources, and work with you and your PCP to get any other services you need to keep you healthy.

If you want a Case Manager, please call Member Services at 1-888-788-4408 (TTY/TDD: 711) for a referral. Your PCP can refer you to Case Management as well.

DISEASE MANAGEMENT

Disease Management is another service offered at no cost to our members. If you have a health problem such as 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 at 1-888-788-4408 (TTY/TDD: 711) if you want to be referred for disease management or for more information.

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.

Health Net Access 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.

NON-COVERED SERVICES: WHAT DOES AHCCCS NOT COVER?

- Non-emergency 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 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).

**A well-child visit/check is synonymous with EPSDT.*

EXCLUSIONS AND LIMITATIONS TABLE

The following services are not covered 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.	Health Net Access 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	The number of respite hours available to adults and children under ALTCS benefits or behavioral health services is 600

	members to take time for themselves.	hours within a 12 month period of time. The 12 months will run from October 1 to September 30 of the next year.
Emergency Dental Service	Emergency services are when you have a need for care immediately like a bad infection in your mouth or pain in your teeth or jaw.	Covered dental services for members 21 years of age and older must be related to the treatment of an emergency condition such as acute pain, infection, 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. Certain pre-transplant services and prophylactic extraction of teeth in preparation for radiation treatment of cancer of the jaw, neck or head are also covered.
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 blood 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.

Health Net Access 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.

END OF LIFE CARE

End of Life (EOL) 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.

EOL care also allows members to receive Advance Care Planning, palliative care, supportive care and hospice services.

REFERRALS

A referral is when your PCP sends you to a specialist for a specific problem. A referral can also be to a lab or hospital. We may need to review and approve certain referrals and special services before you can get the services.

You do not need a referral for the following:

- Emergency Services,
- Behavioral Health services (see *Behavioral Health Services* section for more information)
- OB/GYN services, and
- Dental services for children under the age of 21.

HOW TO GET CARE FROM A SPECIALIST

Some medical services and specialists need our prior approval. If they do, your PCP will arrange for a Prior Authorization for these services. We must review these requests. Your PCP'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.

If your PCP's 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 it.

You may contact Health Net Access or your PCP if you feel you need a referral for specialized care.

If you have a question about the denial, you may call Member Services at 1-888-788-4408 (TTY/TDD: 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.
Please note: Women 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.

Your PCP may want you to see a specialist or get special services. Your PCP will arrange for the special services listed below. Some of these special services may require Prior Authorization.

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

Health Net Access offers members the freedom of choice in selecting doctors in our network. You may change your PCP anytime the following situations apply:

- Your PCP is no longer in your area
- Because of religious or moral reasons, the PCP does not provide the services you seek
- You want the same PCP as other family members
- You are not comfortable talking to your PCP
- Your PCP office is too far

HOW TO GET A SECOND OPINION

You have the right to have a second opinion from a qualified health care professional within the network. If one is not available in the network, you have the right to a second opinion outside the network at no cost to you. We will help you arrange the second opinion visit.

CARE OUTSIDE OF THE HEALTH NET ACCESS NETWORK

In special cases you may be able to get services outside of your county and outside of our network. This includes:

1. Emergency and urgent care services
2. Specialty care when a specialist is not available within our network
3. When arranged by your doctor and approved by our plan for Medically Necessary care

Please contact Member Services if you would like more information.

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.

WHO GIVES ME HEALTH CARE?

YOUR PCP GIVES YOU MOST OF YOUR CARE

Your Primary Care Provider (PCP) is the "gatekeeper" for all services you receive. Your PCP may be providing you medical services or your PCP may make plans for you to get these services from another provider (sometimes called a specialist). **You must see your PCP before you see any other provider or attempt to get outside services.** Our plan may also coordinate your care with schools and state agencies as required by law.

You do not have to see your PCP for the following:

- Emergency Services,
- Behavioral Health services,
- OB/GYN services, and
- Dental services for children under the age of 21.

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 www.healthnetaccess.com or by calling Member Services at 1-888-788-4408 (TTY/TDD: 711). For more information, please see the section titled "*Provider Directory*" in this handbook.

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 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 Health Net Access ID card), your doctor's name, and why you need to see this doctor.

How to Change an Appointment:

- 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 Member Services.

WELL VISITS

Well visits (well exams) such as, but not limited to, well woman 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)

YEARLY WOMEN'S PREVENTATIVE CARE SERVICES

A Well-Woman preventive care visit is a health checkup you get once a year with your doctor at no cost. This means there is no copayment or other charges for your well-woman preventive care visit.

What is a well-woman preventive care visit?
Preventive care can help you stay healthy and keep you from getting sick. A yearly well-woman preventive care visit is a covered benefit you get as a Health Net Access member. You get services such as:

- Physical exam for your overall health.
- Breast exam.
- Pelvic exam.
- Immunizations (shots) and tests based on your age and any risk factors.
- Ideas on how to live a healthy lifestyle and reduce your health risks.

Call for an appointment
It is important to meet with your main doctor listed on your ID card each year. If you need a ride to your doctor appointment, call Health Net Access Member Services at 1-888-788-4408. We can help you.

Visit the Health Net Access website at www.healthnetaccess.com to get details about your health plan. You'll also find wellness information to help you stay healthy.

Important note: **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.**

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
- By 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.*

Important note: **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.**

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 Health Net Access Member Services at 1-888-788-4408 (TTY/TDD: 711).

If you lose eligibility for AHCCCS services, Health Net Access 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. Planned Parenthood provides low-cost family planning services.

MATERNITY CARE

When you become pregnant, we want you to have a healthy pregnancy and a healthy baby. Maternity care includes identification of pregnancy prenatal care, labor and 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.

Preconception counseling services, as part of a well woman 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 a woman is healthy prior to pregnancy. Preconception counseling does not include genetic testing.

Pregnancy Identification

As soon as you think you are pregnant, call your primary care physician or 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 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. Health Net Access has case managers to assist our providers with maternity care coordination. You can change providers or plans during your pregnancy. If you need help, the case

managers can help you. Call Member Services if you need help for any of these reasons.

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. Cenpatico IC can help. Call Health Net Access Member Services for information about confidential testing or counseling services.

High Risk Pregnancy

High-risk pregnancy refers to a pregnancy in which the mother, 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.
Health Net Access has case managers that can help you with your high risk pregnancy at no cost to you. Our case managers can answer your questions and help you with your appointments or referrals. If you want to talk to one of our case managers, please call Member Services at 1-888-788-4408 (TTY/TDD: 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 women 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 women 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.

Important Note: Family Planning services are available to members of any gender who are of reproductive age. 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.

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.

FAMILY RESOURCES

PREGNANCY AND BREASTFEEDING HOTLINE

1-800-833-4642

WOMEN, INFANTS AND CHILDREN (WIC)

As a member, you may be eligible for the Women, Infants and Children (WIC) program. WIC helps families with young children get food, formula and even offers nutrition classes. WIC serves pregnant, breastfeeding, postpartum women, and infants and children under the age of five years. For more information or help finding a WIC office near you, please call 1-800-252-5942.

CHILDREN WITH SPECIAL HEALTH CARE NEEDS

With an approved Prior Authorization, our plan covers incontinence briefs (diapers), including pull-ups for members age 3 years to 20 years old with a documented medical health need. Any approval for incontinence briefs is good for one year. If your child has been diagnosed with certain health

conditions, we will help refer your child to a special health plan for children with special health care needs, which provides services through Children's Rehabilitative Services (CRS). If you have questions about this program, please call Member Services at 1-888-788-4408 (TTY/TDD: 711).

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 to ask to keep that dentist.

Health Net Access 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.

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 Health Net Access ID card with you to the dental appointment.

Members 21 years of age and older

Limited dental services are covered. Adult members 21 years of age and older with emergency dental services, limited to a $1000 member per contract year. 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. 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.

It is important to visit the dentist for checkups two times every year. Call Member Services to make a dental appointment. Once you have found a dental provider, please call their office to change or cancel appointments.

PHARMACY BENEFITS: HOW DO I GET PRESCRIPTION DRUGS?

Health Net Access has contracted with every major pharmacy in our service area as well as most independent pharmacies. If you have questions about what pharmacies are in our network, please call our member service line. It is important to remember that Health Net Access will only approve prescriptions from pharmacies within our service area.

If you need to get medication from a pharmacy afterhours, on a weekend or a holiday, all prescriptions must be filled at a pharmacy in Health Net Access's network. If you need pharmacy services after hours, on weekends or on holidays, many pharmacies are open 24 hours, 7 days a week.

If you have any questions or need assistance, or are turned away at the Point of Sale, please call Member Services at 1-888-788-4408 (TTY/TDD: 711).

If you need medicine, your doctor will choose one from our list of covered drugs and write you a prescription. Ask your doctor to verify that the medication is on our list of covered drugs.

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. Some over-the-counter medicines are also covered when a prescription is written by your doctor. All prescriptions should be filled at a pharmacy listed in your Provider Directory. 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.

If you need medicine, your doctor will choose one from our list of covered drugs. Ask your doctor to verify that the medication is on our list of covered drugs.

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. Some over-the-counter medicines are also covered when a prescription is written by your doctor. All prescriptions should be filled at a pharmacy listed in your Provider Directory. 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 more information, please see section titled *"Co-payments (AHCCCS Co-payments)"* in this handbook.

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.

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

IMPORTANT INFORMATION FOR AHCCCS MEMBERS WITH MEDICARE PART D COVERAGE (DUAL ELIGIBLE MEMBERS)

AHCCCS **does not pay** for any drugs paid by Medicare Part D, or for the cost sharing of these drugs. Cost sharing refers to coinsurance, deductibles, and/or copayments.

AHCCCS **does not pay** for barbiturates to treat epilepsy, cancer, or mental health problems or any benzodiazepines for members with Medicare. AHCCCS pays for barbiturates for Medicare members that are **not** used to treat epilepsy, cancer, or chronic mental health conditions.

EXCLUSIVE PHARMACIES

Health Net AHCCCS may assign members exclusive pharmacies. Exclusive pharmacies are chosen by the member or assigned by Health Net AHCCCS 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.

BEHAVIORAL HEALTH SERVICES

As an AHCCCS member, you are also entitled to a wide range of mental health/behavioral health benefits provided by the Regional Behavioral Health Authority (RBHA) provider in your county.

Your PCP may be able to help you if you have depression (including "postpartum" depression), anxiety or Attention Deficit Hyperactivity Disorder (ADHD). Your PCP may give you medicine, watch how the medicine is working and order different tests to rule out other causes of your illness. Please call your PCP directly for help if you feel you have depression, anxiety or ADHD. You do not need a referral from your PCP for other behavioral health services.

The RBHA provider in Maricopa County is Mercy Maricopa Integrated Care.
If you would like behavioral health services, call Mercy Maricopa Integrated Care directly at the numbers listed below to set up an appointment.

Mercy Maricopa Integrated Care
Phone: 1-602-586-1841 or 1-800-564-5465
Deaf or Hard of Hearing (TTY/TDD): 711
Website: http://www.mercymaricopa.org/

When you contact your RBHA provider, they will tell you what services you are eligible for. If you need to change your behavioral health doctor, talk to your RBHA provider.

Drugs ordered by your RBHA provider are part of your benefit.

BEHAVIORAL HEALTH EMERGENCIES

If you have a behavioral health emergency, it is important to get help right away. Call the Maricopa County 24-Hour Crisis Line at 1-602-222-9444 or 1-800-631-1314 TTY 1-800-327-9254. **You should call 911 if you are having a life-threatening medical emergency or if you are going to hurt yourself or someone else.**

Members (including members who also have Medicare coverage) may be eligible for the following behavioral health services:

- Case management services
- Behavior management (home care training, behavioral health self-help/ peer support)
- Psychotropic medications
- Psychotropic medication adjustment and monitoring
- Behavioral health nursing services
- Emergency or crisis services
- Emergency and non-emergency medically necessary transportation
- Screening, evaluation and assessment
- Individual, group and family counseling and therapy
- Inpatient hospital services
- Institute for mental disease (limited)
- Laboratory, radiology and medical imaging services for psychotropic medication regulation and diagnosis
- Opioid Agonist treatment
- Inpatient behavioral health facility services
- Substance abuse (drug & alcohol) counseling
- Respite care (with limitations)
- Behavioral health supportive home care services
- Partial Care (supervised day program, therapeutic day program

and medical day program)
- Psychosocial rehabilitation (living skills training, health promotion; supportive employment services)

BEHAVIORAL HEALTH SERVICES FOR MEMBERS WHO ALSO HAVE MEDICARE COVERAGE

Health Net Access coordinates your care and/or benefits with your primary insurance, Medicare or Medicare Advantage. Call your Medicare or Medicare Advantage plan first for behavioral health services.

For behavioral health services not covered under your Medicare or Medicare Advantage plan, call us at **1-855-299-3196 (**TTY/TDD: 711**)** to get a referral to a provider or to get help setting up an appointment.

When you contact us, we will tell you what services you are eligible to receive and help you choose your behavioral health provider.

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 adopted by ADHS that incorporate evidence-based "best practice."
   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 supports 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

Multispecialty Interdisciplinary Clinics (MSICs) are clinics where members with qualifying CRS conditions can see their medical specialists and any others involved in their care.

WHO IS ELIGIBLE FOR CHILDREN'S REHABILITATIVE SERVICES (CRS)?

To be eligible for Children Rehabilitative Services (CRS) services your child must:

- Have a CRS eligible diagnosis;
- Be under age 21;
- Be a U.S. citizen or a qualified resident;
- Live in Arizona; and

Require multispecialty physician services

AHCCCS members under the age of 21 will be enrolled into the CRS Program when the presence of a CRS-covered condition requiring active treatment.

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

CRS PROVIDERS

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. CRS MSICs 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

If AHCCCS determines that your child is eligible for the CRS program, your child will be enrolled in a plan with a CRS provider. **Remember**: Health Net Access is not 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.

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 CRS 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.

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/TDD: 1-888-788-4872).
**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.

APPROVAL AND DENIAL PROCESS

Some medical services may need Prior Authorization. If they do, your provider will arrange for authorization for these services. We must review these authorization requests before you can get the service.

Criteria that decisions are based on are available upon request.

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.

If you or your provider would like a referral to a service that is not a covered benefit, please call Member Services so we can discuss other options available to you.

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

Your PCP's office 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/TDD: 711). Criteria that decisions are based on are available upon request. 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.

Your PCP may be providing you these services or your PCP may make plans for you to get these services from another provider (sometimes called a specialist). **You must see your PCP before you see any other provider or attempt to get outside services.**

Remember: You do not have to see your PCP for Emergency Services, Behavioral Health services, OB/GYN services, and Dental services for children under the age of 21.

COPAYMENTS (AHCCCS 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.

THE FOLLOWING PERSONS ARE NOT ASKED TO PAY COPAYMENTS:

- People under age 19,
- People determined to be Seriously Mentally Ill (SMI),
- An individual eligible for the Children's Rehabilitative Services program under A.R.S. §36-2906(E),
- Acute care 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.

In addition, 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 women,
- 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 Health Net Access member services. You can also check the Health Net Access 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.

PAYING FOR COVERED SERVICES

BILLING FOR A COVERED SERVICE

Except for required copays, you should not receive a bill for services covered under the plan. Please call Member Services right away if you receive a bill for medical services. We will make sure the doctor stops sending you a bill.

PAYING FOR COVERED SERVICES

You should not be asked to pay for a covered service. Doctors, hospitals and pharmacies can verify your coverage through AHCCCS or by calling Member Services. If you do have to pay for a pharmacy service, please contact Member Services for directions on how to be reimbursed.

PAYING FOR NON-COVERED SERVICES

We will only cover care approved by our plan, unless it is an Emergency Service. For more information on Emergency care, please see section titled *"Emergency Care: How Do I Get Care in an Emergency?"* in this handbook. If you obtain a service or prescription that is not covered by our plan, Health Net Access will not be responsible for payment and you might receive a bill for any services received. 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. If you are billed for any services, please call us.

CHILDREN'S REHABILITATIVE SERVICES (CRS) COPAYMENTS AND DEDUCTIBLES

If you are a CRS eligible member and have private insurance or Medicare, you are not required to use CRS services for a CRS covered condition. If you choose to use your private insurance or Medicare for a CRS covered condition, we will pay all applicable deductibles and copayments.

However, when your private insurance or Medicare is exhausted, or certain annual or lifetime limits are reached, we will refer you to AHCCCS to determine whether you are eligible for CRS services. If you choose to enroll in CRS for services, CRS will pay all applicable deductibles and copayments. If you choose to not enroll with CRS, and it is determined that you have a CRS eligible condition, we will not pay for services to treat that condition.

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.

AHCCCS **does not pay** for barbiturates to treat epilepsy, cancer, or mental health problems or any benzodiazepines for members with Medicare. AHCCCS pays for barbiturates for Medicare members that are **not** used to treat epilepsy, cancer, or chronic mental health conditions.

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: WHAT SHOULD I DO IF I AM UNHAPPY?

For inquiries to any of the following questions, or to file a complaint, please contact our Appeals & Grievances Department.

Phone: 1-888-788-4408
TTY/TDD: 711

Fax: 1-855-844-0687

Mailing Address:

Health Net Access
Attn: Appeals & Grievances Department
PO Box 9007
Tempe, AZ 85281-9707
Hand deliveries may be delivered to:

Health Net Access
Attn: Appeals & Grievances Department
1230 W Washington Street, Suite 401
Tempe, AZ 85281

WHAT IF YOU HAVE QUESTIONS, PROBLEMS OR GRIEVANCES ABOUT HEALTH NET ACCESS?

Contact us directly if you have a specific grievance or dissatisfaction with any aspect of your care. A grievance is a complaint. Examples of grievances are: service issues, transportation issues, quality of care issues and provider office issues.

You may file your grievance (complaint) in person, verbally or in writing. Your grievance will be reviewed and a response will be provided no later than ninety (90) days from the date that you contact us.

APPEAL AND REQUEST FOR STATE FAIR HEARING

What Is The Meaning Of Some Of The Words Used In This Section?

The word "Action" means an action Health Net Access has taken to deny or limit authorization of a requested service; or the reduction, suspension or termination of a previously approved service.

The word "Appeal" means a request for a review of an "Action."

The phrase "Notice of Adverse Benefit Determination letter" is a written notice from Health Net Access regarding an "Action" Health Net Access has taken.

WHAT IF YOU DISAGREE WITH A DENIED SERVICE?

If you are dissatisfied with an "action" or denial of services by Health Net Access, you may file an "appeal". An appeal must be filed within sixty (60) days from the date of your denial, suspension, reduction or termination Notice of Adverse Benefit Determination letter. You may call Member Services to file an appeal or you can mail or fax the Appeals and Grievance Department at the address and fax number that appears below.

You also have the right to contact AHCCCS Clinical Resolution Unit at 602-364-4575 if Health Net Access does not resolve your concern with the Notice of Adverse Benefit Determination letter.

WHO MAY FILE AN APPEAL?

You, as the member, your authorized representative, or a legal representative of a deceased member's estate, may file an appeal. A provider, acting on your behalf and with your written consent, may file an appeal.

WHAT CAN YOU FILE AN APPEAL FOR?

The reasons you may file an appeal are:

- Denial or limited authorization of a requested service, including the type or level of service
- Reduction, suspension, or termination of a previously authorized service
- Denial, in whole or in part, of payment for a service
- Failure to provide services in a timely manner

- Failure to act within the timeframe required for standard and expedited resolution of appeals and standard disposition of grievances
- The denial of a rural enrollee's request to obtain services outside of our network when Health Net Access is the only contractor in the rural area.

WHAT ARE OUR TIMEFRAMES TO MAKE DECISIONS ABOUT SERVICES?

We have 14 days to review and decide if the requested services are not approved. For an expedited or fast request, we have 72 hours to make a decision. We will notify you in writing if the services are not approved, and will also notify your provider. If a reduction, suspension, or termination of your service happens, we will notify you at least ten (10) days before the change.

WHAT WE WILL DO WHEN YOUR APPEAL IS RECEIVED

We will send you a letter within five (5) business days to let you know that we received your appeal. The letter will also tell you how you can give us more information about your appeal in person or in writing. We will review your appeal and send you a decision letter within thirty (30) days.

For all appeals, we can take an additional fourteen (14) days to decide on your case. This is called an extension. An extension is taken when it is in your best interest to take extra time to make our decision. We may need an extension to make sure we have all information needed; we will notify you in writing and tell you why it is needed and how it is helpful to you. If you want an extension, you can ask for it in writing or by calling us. If we deny your appeal, you may ask for a State Fair Hearing.

HOW DO YOU REQUEST A STATE FAIR HEARING?

If you are not satisfied with the appeal decision, you may file a request for State Fair Hearing with us. This request must be made in writing within 30 days of the date of receipt of the appeal decision. You can mail or fax your request. We will send your appeal file to AHCCCS Office of Administrative Legal Services (OALS) and a hearing date will be scheduled for you to attend. Additionally, there are Legal Services Programs in your area that may be able to help you with the hearing process. General legal information about your rights can also be found on the internet at the following website: *www.azlawhelp.org*.

WHAT IS AN EXPEDITED APPEAL?

If you or your provider feel that your health or ability to function would be harmed by waiting thirty (30) days, you, your authorized representative, or your provider acting on your behalf and with your written consent, may ask for an expedited appeal. If we agree, we will decide your appeal in three (3) working days. If we don't agree that a fast review is needed, we will write you in two (2) days and will also try and contact you by phone. We will then decide your appeal within thirty (30) days.

IF YOU ARE CURRENTLY RECEIVING THE SERVICES REQUESTED, CAN YOU CONTINUE TO RECEIVE THEM DURING THE APPEAL PROCESS?

Yes, but the request must be in writing and be received by us within ten (10) days of the receipt of the Notice of Adverse Benefit Determination letter, or the intended date of the Action, whichever is later. Services will be continued if the services were previously authorized and the original period covered by the authorization has not expired. However, you may be responsible for

payment of those services if we uphold the denial.

IF YOU ARE CURRENTLY RECEIVING THE SERVICES REQUESTED, CAN YOU CONTINUE TO RECEIVE THEM DURING THE STATE FAIR HEARING PROCESS?

Yes, but the request must be in writing and be received by us within ten (10) days of the receipt of the Notice of Adverse Benefit Determination letter, or the intended date of the Action, whichever is later. Services will be continued if the services were previously authorized and the original period covered by the authorization has not expired. However, you may be responsible for payment of those services if the AHCCCS Office of Administrative Legal Services (OALS) upholds the denial.

MEMBER RIGHTS

Our goal is to provide high-quality medical care and advanced medical treatment. We also promise to listen, treat you with respect, and understand your individual needs. The following is a description of your rights as a member.

MEMBER RIGHTS

As a member, you have the right to:

- Complain about the managed care organization (Health Net Access). Please call us if you have any issues or concerns with your care.
- Request information on the structure and operation of Health Net Access or our subcontractors.
- Request information on whether Health Net Access has physician incentive plans (PIP) that affect the use of our referral services
- Know the types of compensation arrangements Health Net Access uses
- Know whether stop-loss insurance is required
- Receive a summary of member survey results
- Be treated fairly regardless of race, religion, color, creed, national origin, disability, sexual orientation, gender, gender identity, age, marital status, ability to pay
- You have the right to have a second opinion from a qualified health care professional within the network. If one is not available in the network, you have the right to a second opinion outside the network at no cost to you. We will help you arrange the second opinion visit.
- 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
- Have access to review medical records in accordance with applicable federal and state laws 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 493.3(a)(2).

- 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 PCPs through the Provider Directory, including those who speak a language other than English and who are able to accommodate members with disabilities
- Seek care at any hospital for emergency care
- Have services provided in a culturally competent manner, with consideration for members with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, or visual or auditory limitations
- Select a primary care physician (PCP) from Health Net Access'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
- Request a copy of the Notice of Privacy Practices at no cost to you. The notice describes Health Net Access' 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.

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 Health Net Access at 1-888-788-4408, TTY/TDD 711.

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 Health Net Access to ask to see or get a copy of your medical record. Health Net Access Member Services can help you. Just call 1-888-788-4408, TTY/TDD 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.

Health Net Access has a Notice of Privacy Practices (NPP) available at any time. You can access this NPP by calling member services at 1-888-788-4408, TTY/TDD 711 to request a copy.

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.

FRAUD, WASTE AND ABUSE

WHAT IS FRAUD AND ABUSE?

Fraud and abuse 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 and Abuse include but are not limited to:

- Lending or selling your AHCCCS

Identification Card to anyone.
- Changing prescriptions written by any of our providers.
- Giving incorrect information on your AHCCCS application.

Examples of Provider Fraud and Abuse 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.

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

How to Report Fraud and Abuse:
If you suspect one of our providers or members of fraud and abuse, please contact Health Net Access's toll-free Fraud and Abuse Hotline at 1-800-977-3565. The Fraud Hotline operates 24 hours a day, seven days a week. All calls are strictly confidential.

You may also report Fraud and Abuse to AHCCCS at 1-602-417-4193.

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.

ADVANCE DIRECTIVES

The law requires doctor and health care facilities to inform you, in writing, of your right to create an "Advance Directive" relating to your medical care. Advance Directives are used to allow you to make medical decisions about yourself should you no longer be able to do so. The two most common Advance Directives are the Living Will and the Durable Power of Attorney.

Even though you have made an Advance Directive, your PCP may still choose whether to follow your wishes. You cannot be denied care without these documents, but without written instructions, a judge may have to make a personal and medical decision for you. Tell your family and PCP where you keep your Advance Directive. Ask your PCP to make the Advance Directive a part of your medical record.

The Living Will gives information about whether you want or don't want life sustaining procedures if you have a condition that cannot be cured or improved. A Medical Power of Attorney allows you to name a person you trust to decide what type of treatment you will receive if you are unable to decide for yourself.

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 http://www.azdhs.gov/prevention/tobacco-chronic-disease/tobacco-free-az/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.

Children's Action Alliance
The Children's Action Alliance (CAA) of Arizona promotes the well-being of Arizona's children through advocacy, education, and research. For more information, please contact CAA at caa@azchildren.org or at 1-602-266-0707. Their address is 4001 North Third Street, Suite 160, Phoenix, AZ 85012.

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 1-928-458-0117.

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.

AHCCCS

Please visit **www.healthearizonaplus.gov** and **www.azlinks.gov** to find out more information that can help you and your family stay healthy. You can also contact AHCCCS at 1-800-654-8713 or 1-602-417-4000.

ALZHEIMER'S ASSOCIATION

The Alzheimer's Association provides education and resources to those affected by Alzheimer's disease. Visit www.alz.org or call (800) 272-3900 for more information.

AREA AGENCY ON AGING

The Area Agency on Aging, Region One, offers a large variety of programs and services that enhance the quality of life for residents of Maricopa County, Arizona. We advocate, plan, coordinate, develop and deliver services for adults aged 60+, adults aged 18+ with HIV/AIDS, adults aged 18+ with disabilities and long-term care needs, and family caregivers. Visit https://www.aaaphx.org/ or call **24-Hour *Senior* HELP LINE at 602-264-HELP (4357) or 888-783-7500**

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.

www.azdes.gov/AzEIP
3839 N. 3rd Street, Suite 304
Phoenix, AZ 85012
1-602-532-9960 or 1-888-439-5609

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.

Website: www.azspc.org

DEPARTMENT OF ECONOMIC SECURITY (DES)

1-800-352-8401 or 1-602-542-9935
www.azdes.gov

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.

www.azheadstart.org
3910 S. Rural Road
Tempe, AZ. 85282
1-480-829-8868 or 1-866-763-6481

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);
928-726-1983 (Yuma)

Website: http://www.mikid.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: 602-244-8166

Website: www.namiaz.org

SOCIAL SECURITY

1-800-772-1213

WOMEN, INFANT AND CHILDREN (WIC)

1-800-252-5942
http://azdhs.gov/azwic/

ADVOCACY INFORMATION

Member Services coordinates with our public programs department to identify members with special health care needs, improve member access to health care and enhance member care coordination. Our public programs department has public programs coordinators who are licensed vocational nurses and certified medical assistants working with members who need services from community service organizations, state sponsored programs and health care providers. Here are a few examples of what the public programs coordinators assist members with:

- Refer members to case managers to develop a case management plan
- Provide members, parents, or legal guardians information about public programs available to them
- Discuss members' special needs with their PCP
- Identify members' needs, including barriers to health care access

To find out more about our public programs coordinators, please call Member Services.

In addition, the following organizations can provide advocacy assistance for you:

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.

LOW COST/SLIDING SCALE HEALTH CARE

MARICOPA COUNTY

Adelante Healthcare

Avondale
Coronado Professional Plaza
3400 Dysart Rd, Ste F-21
Avondale, AZ 85392
Phone: 1-877-809-5092

Buckeye
306 E Monroe Ave
Buckeye, AZ 85326
Phone: 1-877-809-5092

Gila Bend
100 N Gila Blvd
Gila Bend, AZ 85337
Phone: 1-877-809-5092

Mesa
1705 W Main St
Mesa, AZ 85201
Phone: 1-877-809-5092

Phoenix
7725 N 43rd Ave, Ste 510
Phoenix, AZ 85201
Phone: 1-877-809-5092

Surprise
15351 W Bell Rd
Surprise, AZ 85374
Phone: 1-877-809-5092

Wickenburg
811 N Tegner St, Ste 113
Wickenburg, AZ 85390
Phone: 1-877-809-5092

John C Lincoln Community Health Center
(AKA Desert Mission Health Center)
9201 N 5th St
Phoenix, AZ 85020
Phone: 1-602-331-5779
Maricopa Integrated Health System

McDowell Healthcare Center
1101 N Central Ave 2nd Floor
Phoenix, AZ 85004
Phone: 1-602-344-6550

Sunnyslope Family Health Center
934 W Hatcher Rd
Phoenix, AZ 85021
Phone: 1-602-344-6550

Comprehensive Health Center
2525 Roosevelt St
Phoenix, AZ 85008
Phone: 1-602-344-1015

Guadalupe Family Health Center
5825 Calle Guadalupe
Guadalupe, AZ 85283
Phone: 1-480-344-6000

South Central Family Health Center
33 W Tamarisk St
Phoenix, AZ 85041
Phone: 1-602-344-6400

Mountain Park Health Center - Baseline
635 E Baseline Rd
Phoenix, AZ 85042
Phone: 1-602-243-7277

Maryvale Family Healthcare

4011 N 51st Ave
Phoenix, AZ 85031
Phone: 1-623-344-6900

Maricopa County Health Care For The Homeless
220 S 12th Ave
Phoenix, AZ 85007
Phone: 1-602-372-2100

Chandler Family Health Center
811 S Hamilton St
Chandler, AZ 85225-6308
Phone: 1-480-344-6100

El Mirage Family Health Center
12428 W Thunderbird Rd
El Mirage, AZ 85335-3113
Phone: 1-623-344-6100

Avondale Family Health Center
950 E Van Buren St
Avondale, AZ 85323-1506
Phone: 1-623-344-6100

Glendale Family Health Center
5141 W Lamar St
Glendale, AZ 85301-3423
Phone: 1-623-344-6700

Mesa Family Health Center
59 S Hibbert
Mesa, AZ 85210-1414
Phone: 1-480-344-6200

Seventh Ave Family Health Center
1205 S 7th Ave
Phoenix, AZ 85007-3904
Phone: 1-602-344-6600

Mountain Park Health Centers

Tempe Community Health Center
1492 S Mill Ave #312
Tempe, AZ 85281
Phone: 1-602-243-7277

Mountain Park Health Center - Goodyear
140 N Litchfield Rd
Goodyear, AZ 85338
Phone: 1-602-243-7277

Mountain Park Health Center - East Phoenix
690 N Cofco Center Ct, Ste 230
Phoenix, AZ 85008-6464
Phone: 1-602-286-6090

Native American Community Health Center, Inc.
4520 N Central Ave, Ste 350
Phoenix, AZ 85012-3020
Phone: 1-602-279-5262

Armadillo Pediatrics
515 W Buckeye Rd, Ste 402
Phoenix, AZ 85003-2651
Phone: 1-602-257-9229

Estrella Family Medical -Maryvale
4700 N 51 Ave, Ste 1
Phoenix, AZ 85031
Phone: 1-623-344-6900

OSO Medical
378 N Litchfield Rd
Goodyear, AZ 85338-1239
Phone: 1-623-925-2622

St Vincent De Paul /Virginia G. Piper Medical & Dental Clinic
420 W Watkins Rd
Phoenix, AZ 85003-2830
Phone: 1-602-261-6868

Thank you for choosing Health Net Access. We look forward to serving you

TERMS & DEFINITIONS

638 Tribal Facility means a facility operated by an Indian tribe authorized to provide services pursuant to Public Law 93-638, as amended.

Action is the denial or limited approval of a requested service, including the type or level of service, a reduction, suspension or termination of a service someone has been 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 established timeframes for resolving an appeal or complaint and providing notice to affected parties, and , the denial of the Title 19/21 eligible person's request to get services outside the network when services are not available within the provider network.

Advance Directive is a written instruction telling your wishes about what types of care you do or do not want.

Appeal is a formal request to review an action or decision related to your behavioral health service that you could file if you are not happy with an action, or adverse decision for persons determined to have a Serious Mental Illness, taken by a provider or Mercy Maricopa.

Approval of services is the process used when certain non-emergency services require approval before you can get them.

Arizona Health Care Cost Containment System (AHCCCS) is the state agency that oversees the use of federal and state funds to provide behavioral health services, Title 19 (Medicaid), Title 21 and Arizona Long Term Care Services (ALTCS) programs.

Auricular Acupuncture is provided by a certified acupuncturist practitioner, who uses auricular acupuncture needles to treat alcoholism, substance abuse or chemical dependency.

Behavioral health provider is whom you choose to get behavioral health services from. It can include doctors, counselors, other behavioral health professionals/ technicians and behavioral health treatment centers.

Clinical team is a Child and Family Team or Adult Recovery Team.

Complaint is the expression of dissatisfaction with any aspect of your care that isn't an action you can appeal.

Consent to treatment is giving your permission to get services.

Co-payment (copays) are amounts members pay directly to a provider for each item or service they receive at the time of a service. Copays can be mandatory (also known as required) or optional (also known as nominal). Certain services and populations are exempt from any copays which means that no mandatory or optional copays will be charged.

Cost sharing refers to a responsibility for payment of applicable premiums, deductibles and copayments.

Culture includes but is not limited to the languages we speak, our thoughts, how we talk with each other, relationships, actions, customs, beliefs, values, age, physical abilities or limits, traditions, gender identity,

sexual orientation, where we live, and also racial, ethnic, and religious or social groups.

Emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the patient's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Emergency medical transportation is Ambulance services for an emergency medical condition.

Emergency room care are emergency services you get in an emergency room.

Emergency Services refer to an evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Enrolled is the process of becoming eligible to receive public behavioral health services.

Excluded services Health care services that your health insurance or plan doesn't pay for or cover.

Expedited appeal is an appeal that is processed sooner than a standard appeal in order to not seriously jeopardize the person's life, health or ability to attain, maintain or regain maximum functioning.

Grievance/Request for Investigation is for persons determined to have a serious mental illness when they feel their rights have been violated.

Habilitation services and devices are Health care services that help you keep, learn, or improve skills and functioning for daily living. These services may include physical and occupational therapy, speech-language therapy, and other services.

Health insurance is a financial protection against the medical care costs arising from disease or accidental bodily injury. Such insurance usually covers all or part of the medical costs of treating the disease or injury.

Home Health Care entails health care services a person receives at home.

Hospice Services are Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization is Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital outpatient care means Care in a hospital that usually doesn't require an overnight stay.

Indian Health Service (IHS) means the bureau of the United States Department of Health and Human Services that is responsible for delivering public health and medical services to American Indians and Alaskan Natives throughout the country. The federal government has direct and permanent legal obligation to provide health services to most American Indians according to treaties with Tribal Governments.

Member is a person enrolled with a RBHA to get behavioral health services.

Network The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Non-participating provider is a provider who doesn't have a contract with your health insurer or plan to provide services to you.

Participating provider means a provider that is contracted with the health insurance plan.

Physician services are Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan referrers to the pairing of the health insurance coverage benefits under a product and a particular cost-sharing structure, provider network, and service area

Power of Attorney is a written statement naming a person you choose to make health care or mental health decisions for you if you cannot do it.

Preauthorization refers to A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Premium refers to The amount you pay for your health insurance every month. In addition to your premium, you usually have to pay other costs for your health care, including a deductible, copayments, and coinsurance.

Prescription drug coverage refers to the Health insurance or plan that helps pay for prescription drugs and medications.

Prescription drugs are Drugs and medications that, by law, require a prescription.

Primary care physician is a physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Provider refers to a person or entity that contracts with an AHCCCS plan to provide covered services directly to members.

Provider network is a group of providers that contract with the RBHAs to provide behavioral health services. Some counties may have a limited number of providers in their provider network to choose from.

Provider preventable conditions are complications or mistakes caused by hospital conditions, hospital staff or a medical professional that negatively affect the health of a member. These conditions are listed in the AHCCCS Medical Policy and Manual, Chapter 1000.

Referral is the process (oral, written, faxed or electronic request) by which your provider will "refer" you to a provider for specialized care.

Regional Behavioral Health Authority (RBHA) is the agency under contract with AHCCCS to deliver or arrange for behavioral health services for eligible persons within a specific geographic area.

Rehabilitation services and devices are Health care services that help you keep, get

back, or improve skills and functioning for daily living that have been lost or impaired because you were sick, hurt, or disabled.
Restraint means personal restraint, mechanical restraint or drug used as a restraint. Personal restraint is the application of physical force without the use of any device, for restricting the free movement of a behavioral health recipient's body. Mechanical restraint is any device, article or garment attached or adjacent to a behavioral health recipient's body that the person cannot easily remove and that restricts the person's freedom of movement or normal access to the person's body. Drug used as a restraint is a pharmacological restraint that is not standard treatment for a behavioral health recipient's medical condition or behavioral health issue and is administered to manage the behavioral health recipient's behavior in a way that reduces the safety risk to the person or others or temporarily restrict the behavioral health recipient's freedom of movement.

Seclusion is the involuntary confinement of a behavioral health recipient in a room or an area from which the person cannot leave or which a person reasonably believes prevents him/her from leaving.

Serious mental illness (SMI) is a condition of persons who are eighteen years of age or older and who, as a result of a mental disorder as defined in A.R.S. § 36-501, exhibit emotional or behavioral functioning which is so impaired as to interfere substantially with their capacity to remain in the community without supportive treatment or services of a long-term or indefinite duration. In these persons, mental disability is severe and persistent, resulting in a long-term limitation of their functional capacities for primary activities of daily living such as interpersonal relationships, homemaking, self-care, employment and recreation.

Service prioritization is the process by which the RBHAs must determine how available state funds are used.

Skilled nursing care skilled nursing care and rehabilitation services provided on a continuous, daily basis in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Title 19 (Medicaid; may also be called AHCCCS) is medical, dental and behavioral health care insurance for low-income persons, children and families.

Title 21 (may also be called AHCCCS) is medical, dental and behavioral health care insurance for children under 19 years of age with low income, no other insurance and who are not eligible for Title 19 (Medicaid).

Traditional Healing Services for mental health or substance abuse problems are provided by qualified traditional healers. These services include the use of routine or advanced techniques aimed to relieve the emotional distress that may be evident by disruption of the person's functional ability.

Tribal Regional Behavioral Health Authority (TRBHA) is an American Indian tribe under contract with AHCCCS to deliver or arrange for behavioral health services for eligible persons who are residents of the federally recognized Tribal Nation.

MEDICAL TERMS
Action, an action by Health Net Access:

- The denial or limited authorization of a service you or your doctor have asked for
- The reduction, suspension or ending of an existing service
- The denial of payment for a service, either all or part
- Failure to provide services in a timely manner
- Failure to act within certain timeframes for grievances and appeals
- Denial of a rural member's request to get services out of the network when Health Net Access is the only health plan in the area

AHCCCS (Arizona Health Care Cost Containment System) is the state agency that manages the Medicaid program in Arizona using federal and state funds. AHCCCS contracts with managed care health plans to deliver medical services to eligible members.

Appeal Resolution is the written determination by Health Net Access about an appeal.

Authorization is an approval from your doctor and/or health plan before getting other health care services including, but not limited to, laboratory and radiology tests and visits to specialists and other health care providers (see referral).

Copayment is a small amount of money you pay when you get certain covered services.

Emergency is a medical situation that could cause serious health problems or even death if not treated immediately.

Durable Medical Equipment (DME) equipment which:

- May be used over and over
- Is primarily used to serve a medical purpose
- Usually is not useful to a person when they are not sick or hurt
- Is easily used in the home

Some examples are crutches, wheelchairs, and walkers.

Family Planning is education and treatment services for a member who voluntarily chooses to delay or prevent pregnancy.

Grievance is any written or verbal expression of dissatisfaction over a matter other than an action, as defined in this Handbook, by a member or provider authorized in writing to act on the member's behalf. A grievance may be submitted orally or in writing to any Health Net Access staff person. Grievances include, but are not limited to, issues regarding:

- Quality of care or services
- Accessibility or availability of services
- Interpersonal relationships (e.g. rudeness of a provider or employee, cultural barriers or insensitivity)
- Claims or billing
- Failure to respect a member's rights

Grievance System is a system that includes a process for enrollee grievances, enrollee appeals, provider claim disputes, and access to the State Fair Hearing system.

Maternity Care includes medically necessary preconception counseling, pregnancy, testing prenatal care, labor and delivery services, and postpartum care.

Medically Necessary is a covered service that will prevent disease, disability and other poor health conditions or their progress, or prolong life.

Medically Necessary Transportation takes you to and from required medical services.

Notice of Adverse Benefit Determination is an action taken if Health Net Access decides that the requested service cannot be approved, or if an existing service is reduced, suspended or ended, a member will receive a "Notice of Adverse Benefit Determination" telling them what action was taken and the reason for it; their right to file an appeal and how to do it; their right to ask for a fair hearing with AHCCCS and how to do it; their right to ask for an expedited resolution and how to do it; and, their right to ask that their benefits be continued during the appeal, how to do it and when they may have to pay the costs for the services.

Obstetrician/Gynecologist (OB/GYN) is a doctor who cares for women during pregnancy, childbirth, postpartum and well-women exams.

OB Case Management is an obstetrical case manager link for expectant mothers with appropriate community resources such as the Women, Infants and Children's (WIC) nutritional program, parenting classes smoking cessation, teen pregnancy case management, shelters, and substance abuse counseling. They provide support, promote compliance with prenatal appointments, and prescribe medical treatment plans.

Out-of-Network Provider is a provider who is neither contracted with nor authorized by Health Net Access to provide services to Health Net Access members.

Postpartum Care is health care provided up to 60 days post-delivery.

Preconception Counseling is the goal is to uncover any high-risk issues and help a woman become healthy before becoming pregnant.

Prenatal Care is health care provided throughout the pregnancy.

Prescription is an order from your doctor for medicine. The prescription may be called in over the telephone or can be written down.

Primary Care Provider (PCP) is the doctor who provides or authorizes all your health care needs. Your PCP refers you to a specialist if you need special health care services.

Provider Fraud & Abuse

- Falsifying Claims/Encounters that include the following items:
  - Alteration of a claim
  - Incorrect coding
  - Double billing
  - False data submitted
- Administrative/Financial actions that include the following items:
  - Kickbacks
  - Falsifying credentials
  - Fraudulent enrollment practices
  - Fraudulent Third Party Liability (TPL) Reporting
  - Fraudulent Recoupment Practices
- Falsifying Services that include the following items:
  - Billing for Services/Supplies Not Provided,
  - Misrepresentation of Services/Supplies
  - Substitution of Services

Qualified Medicare Beneficiaries (QMB) is for members who qualify for both AHCCCS and Medicare who have their Medicare Part A and Part B premiums,

coinsurance and deductibles paid for by AHCCCS.

Regional Behavioral Health Authority (RBHA) is the behavioral health administrator contracted with the Arizona Health Care Cost Containment System (AHCCCS) to deliver behavioral health services in a certain area of the state.

Referral is when the PCP sends you to a specialist for a specific, usually complex, problem.

Specialist is a doctor who treats specific health care needs. For example, a cardiologist is a specialist. You must get a referral from your doctor before seeing a specialist.

Urgent care means care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe it requires 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 women 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 mother, 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, as addressed in Policy 420 of this Chapter.

Preconception counseling services, as part of a well woman 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 a woman is 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

Health Net Access
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.

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

1-888-788-4408.

Interpreter services are provided free of charge to you.

Covered Entities Duties:

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

Health Net Access 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. Health Net access 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 through the member handbook.

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 or lose.

- ***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.

Health Net Access
Attn: Privacy Official
P.O. Box 9103
Van Nuys, CA 91409
1-888-788-440