Health Net Access

Member *Handbook*

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

Benefit Year 2015

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, please contact Member Services at 1-888-788-4408 or TTY/TDD: 1-888-788-4872. Also, if you need interpretive services, please call Member Services at least five (5) days before your medical appointment to arrange language interpretive services in time for your appointments. There is no cost for language interpretation services. You are not required to use family or friends to interpret for you.

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 1-888-788-4872. 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.

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USING THE HEALTH PLAN

Health Net Access is a Managed Care Plan. 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 doctor play an important role in your managed care plan. Your doctor 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).

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

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.

Contract services are funded in part under contract with the State of Arizona.

LET'S GET STARTED: HOW DO I GET HEALTH CARE?

YOUR PRIMARY CARE PROVIDER (PCP)

Your Primary Care Provider (PCP) is your assigned doctor and plays an important role in your health care. Your PCP 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. For more information on emergency room use, please see section titled *"Emergency Care: How Do I Get Care in an Emergency?"* in this handbook.

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.*

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.healthnet.com/access or by calling Member Services at 1-888-788-4408 (TTY/TDD: 1-888-788-4872). 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.

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.

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.

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

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: 1-888-788-4872) to get a new one.

PROVIDER DIRECTORY

A Provider Directory is available online. Visit www.healthnet.com/access 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 to you at no charge by calling Member Services.** The provider directory is available in English and Spanish.

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: 1-888-788-4872), 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 or Spanish, call Member Services and we will help get an interpreter to assist with the phone call.

When calling Member Services, please have the following information ready: Your name, your AHCCCS ID number, your date of birth, the phone number and address on file. You will also need a pen and paper to write down important information we will give you.

Some of the ways Member Services can help you:

- Answer questions about your covered services, benefits, and co-pays
- Provide information about doctors, nurse practitioners, and physician assistants
- Provide information about programs available to members
- Help you choose or change your PCP
- Help you schedule a ride to your doctor or medical appointments
- Help you make, change or cancel your medical appointments
- Provide you with dentist or specialist information
- Help you if you have a complaint or problem
- Help you with your rights as a member
- Help you schedule a language interpreter for your medical appointments if you cannot communicate with your doctor. **This service is provided at no cost to you**.
- Help you change your phone number and address with AHCCCS. If you are currently being treated for conditions such as diabetes, cancer, asthma, behavioral health, HIV/AIDS, or any disability, call Member Services immediately. We will refer you to a Case Manager to make sure you are getting the care you need.

If your address or phone number changes, it is very important that you report it immediately.

- Call Member Services with your new address and phone number.
- Call your local Department of Economic Security (DES) eligibility office with your new address and phone number.
- KidsCare members can call 1-877-764-5437 or 1-602-417-5437 (TDD for the hearing impaired: 1-602-417-4191).

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.

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.

CULTURAL COMPETENCY

We value the many people who live in the areas we serve. We understand that there are many different 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 interpretive services at no cost to you. 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 this or any of our other printed materials in another language, 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, please call Member Services at 1-888-788-4408 (TTY/TDD: 1-888-788-4872).

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.**

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.

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.

If you have a question about the denial, you may call Member Services at 1-888-788-4408 (TTY/TDD: 1-888-788-4872). 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.
**A well-child visit/check is the same as an EPSDT visit.*

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. Diet and health coaching
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

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.

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.

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.

Prior Authorization means your doctor has requested permission for you to get a special service. We must approve these requests before the delivery of services. 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: 1-888-788-4872). 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.

As our member, you may receive the following health care benefits. The list below does not include all possible services. 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.

COVERED SERVICES

The services listed below will be covered with us. 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 for children and QMB
- Emergency medical and surgical services related to dental (oral) care
- 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
- Health care services including screenings, diagnosis and medically necessary treatments
- Hospice care
- Hospital care
- Inpatient rehabilitation services, including speech, physical and occupational therapy. Outpatient physical therapy to restore a level of function is limited to 15 visits per contract year for members 21 years of age and older and

unlimited for members under age 21. Physical therapy to maintain or help achieve a level of function when medically necessary is limited to 15 visits per contract year for members 21 years of age and older. Outpatient occupational therapy and outpatient speech therapy is only covered for members under age 21.

- Insulin Pumps
- Lab work and x-rays
- Medical tests
- Medically needed foot care. For members age 21 and older, services provided by a podiatrist are not covered.
- Medicine from the approved Health Net Access Drug List (Drug List)
- PCP office visits for children*, QMB, or when an adult has a symptom or sickness
- Preventative and routine gynecological services for female members (Direct access, no referral needed)
- 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*
- 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 the EPSDT, *"Well-Child Care / Early Periodic Screening, Diagnostic and Treatment"* section in this handbook, for well-exams for members under 21 years of age).

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

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: 1-888-788-4872) 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: 1-888-788-4872) if you want to be referred for disease management or for more information.

TOBACCO EDUCATION AND PREVENTION

If you are thinking about quitting smoking, ready to quit or working to stay quit, there is help. Members 18 years old and older can enroll in a tobacco cessation program through the Arizona Department of Health Services (ADHS). Members can access the Arizona Smokers' Helpline (ASHLine) at 1-800-556-6222 for free telephone based coaching services. You can also go online at **www.ashline.org** to develop a quit plan, set goals and track your progress or visit **http://www.azdhs.gov/tobaccofreeaz**. Members must contact their Primary Care Provider (PCP) for a prescription for a tobacco cessation product, including those that are available over-the-counter. For prescription drugs, Prior Authorization is required for members under age 18. The PCP will identify an appropriate tobacco cessation product. Through Health Net Access, the maximum supply a member may receive of a tobacco cessation product is a 12-week supply in a six-month time period, which begins on the date the pharmacy fills the first tobacco cessation product.

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. Orthotic devices are not covered for members over the age of 21 years, except under the following circumstances:

a. Halos to treat cervical fracture instead of surgery
b. Walking boots instead of surgery or serial casting
c. Knee orthotics for crutch dependent ambulation instead of a wheelchair

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.

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. It is important to visit the dentist for checkups two times every year. Call Member Services to make a dental appointment.

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

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

Use these guidelines for scheduling appointments for your child:

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

Members 21 years of age and older

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

services if done by a physician. Covered dental services for members 21 years of age and older must be related to the treatment of a medical condition such as 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 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.

BEHAVIORAL HEALTH SERVICES

Your PCP may be able to help you if you have mild depression, "postpartum" depression, anxiety and attention deficit hyperactivity disorder (ADHD). Your PCP may give you medicine, watch how the medicine is working and order different tests for your illness. 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 behavioral health services.

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

Your Health Net Access ID card has a phone number to access behavioral health and substance abuse services. Services are assigned to a provider (RBHA) 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.

Behavioral health services you may be eligible for include:

- 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 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.

MEDICALLY NECESSARY PREGNANCY TERMINATIONS

Pregnancy terminations are an AHCCCS covered service only in special situations. Pregnancy termination is covered if the life of the mother is in danger due to the pregnancy or the pregnancy is due to rape or incest and has been reported to the police or when determined to be medically necessary. A Prior Authorization is needed to cover this service.

WOMEN'S HEALTH SCREENING

Women should get preventative screenings each year. Preventative services include, but are not limited to: screening services such as cervical cancer screening including Pap smear, mammogram *(after age 40 and at any age if considered medically necessary*), colorectal cancer, and screening for sexually transmitted infections.

Female members have direct access to preventive and well care services from a gynecologist within our network without a referral from a primary care provider. Please contact Member Services for more information on Pap smears, mammograms, and colonoscopies.

A pap smear tests for cervical cancer. A mammogram tests for breast cancer.

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

FAMILY PLANNING

Family Planning services are available to both male and female members 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. You may not want to get pregnant if you:

- Are not ready to have a child
- Already have the number of children you want

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

- Birth control pills or shots, condoms, diaphragms, foams
- Natural family planning and referral to qualified health professionals
- Post-coital emergency contraception (also known as the morning after pill)
- Sterilization (male and female) 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 Terminat*ion" section above.
- Hysterectomies if done for family planning only

MATERNITY CARE

When you become pregnant, we want you to have a healthy pregnancy and a healthy baby. Maternity care services include, but are not limited to, medically necessary preconception counseling, identification of pregnancy, medically necessary education and prenatal care, the treatment of pregnancy-related conditions, 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, 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.

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.

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: 1-888-788-4872).

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. You may want to talk about family planning and birth control, which your provider may prescribe for you. 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. Call Member Services or your provider to schedule an appointment.

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.

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

We want to help your children grow up healthy. 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 USC 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 USC 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 28 optional and mandatory categories of "medical assistance" as defined in the Medicaid Act. Services covered under EPSDT include all 28 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.

There is no co-pay for these services. Every growing child should have each of these well-child checkups. These are routine exams especially to keep children healthy. These checkups can help find some health problems early so that they can be treated. Treatment will keep them from becoming more serious. All medically necessary services to treat a physical or mental illness found during a well-child care exam are covered. If your child needs help for behavioral problems, talk to your PCP or call Member Services.

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.*

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: 1-888-788-4872).

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 shall 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 you 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

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. 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

Children's Clinics
Square & Compass Building
2600 North Wyatt Drive
Tucson, AZ 85712
1-520-324-5437
1-800-231-8261

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

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

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.

COMMUNITY RESOURCES

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 1-602-417-7000.

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

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

Social Security
1-800-772-1213

Women, Infant and Children (WIC)
1-800-252-5942
http://azdhs.gov/azwic/

TRANSPORTATION: HOW DO I GET RIDES TO MEDICAL APPOINTMENTS?

EMERGENCY

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.

NON-EMERGENCY

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.

EMERGENCY CARE: HOW DO I GET CARE IN AN EMERGENCY?

EMERGENCY ROOM AND URGENT CARE (AFTER-HOURS CARE) USE

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 (usually in less than an hour). Urgent Care centers can help you with ear infections, sore throats, urinary tract infections, minor cuts and burns, sprains, and other common health issues. Urgent Care can be used for problems your doctor would normally help with.

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

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.**

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.

Should you go to the Emergency Room or Urgent Care?	
Examples of **Emergency Room Symptoms**	Examples of **Urgent Care Symptoms**
• Extreme shortness of breath • Fainting • Poisoning • Chest pains • Uncontrolled bleeding • Seizures	• 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 a fever, earaches

PHARMACY BENEFITS: HOW DO I GET PRESCRIPTION DRUGS?

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. For more information, please see section titled *"Co-payments (AHCCCS Co-payments)"* in this handbook.

WHAT YOU NEED TO KNOW ABOUT YOUR 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 another doctor or medications you buy on your own including non-prescription or herbal products.

The pharmacist will talk to you if you are getting a 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 refill 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 at the point of sale 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: 1-888-788-4872).

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

AHCCCS **does not pay** for any drugs covered by Medicare Part D, or for 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.

CO-PAYMENTS (AHCCCS CO-PAYMENTS)

Some people who get AHCCCS Medicaid benefits are asked to pay copays for some of the AHCCCS medical services that they receive. Copays can be mandatory (also known as required) or optional (also known as nominal).

Some people and certain services are exempt from copays which means that no mandatory or optional copays will be charged.

Copayments are not charged to the following persons:

- Children under age 19
- People determined to be Seriously Mentally Ill (SMI) by the Arizona Department of Health Services
- Individuals up through age 20 eligible to receive services from the Children's Rehabilitative Services program
- People who are acute care members and who are residing in nursing homes or residential facilities such as an Assisted Living Home and only when the acute care member's medical condition would otherwise require hospitalization. The exemption from copayments for acute care 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 P.L. 93638, or urban Indian health programs
- People in the Breast & Cervical Cancer Treatment Program
- 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 the postpartum period following the pregnancy
- People in the Adult Group (for a limited time*)

*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 2015. 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
- Well-visits and preventive services such as pap smears, colonoscopies, and immunizations
- Services paid on a fee-for-service basis.
- Provider preventable services
- Services received in the emergency department

PEOPLE WITH NOMINAL (OPTIONAL) COPAYS

Individuals eligible for AHCCCS through any of the programs below may be charged nominal 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. Nominal copays are also called optional copays. If a member has a nominal 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 a nominal copay by their provider:

- AHCCCS for Families with Children (1931)
- Young Adult Transitional Insurance (YATI) for young adults who were 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 individuals 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 Member Services.

AHCCCS members with nominal copays may be asked to pay the following nominal copays for medical services:

Nominal Copay 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) COPAYS

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 next.

Copayment Amounts for Persons Receiving TMA Benefits:	
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

5% LIMIT ON ALL COPAYS

The amount of total copays cannot be more than 5% of the family's total income during a calendar quarter (January-March, April-June, July-September, and October-December). If this 5% limit is reached, no more copays will be charged for the rest of that quarter. 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, 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 your income or circumstances have changed, it is important to contact the eligibility office right away. Members can always request a reassessment of their 5% limit if their circumstances have changed.

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.

BILLING FOR A COVERED SERVICE

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 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.

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.
- Sex changes.
- 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).

- Chiropractic services except for EPSDT* services.

- 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
Percussive Vests	This vest is placed on a person's chest and shakes to loosen mucous.	AHCCCS will not pay for percussive vests. Supplies, equipment maintenance (care of the vest) and repair of the vest will be paid for.
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.	Orthotic devices are not covered for members over the age of 21 years, except under the following circumstances: 1) Halos to treat cervical fracture instead of surgery; 2) Walking boots instead of surgery or serial casting; 3) Knee orthotics for crutch dependent ambulation instead of a wheelchair. See the "*Orthotics Care*" section for more information.
Respite Care	Short-term or continuous services provided as a temporary break for caregivers and members to take time for themselves.	The number of respite hours available to adults and children under ALTCS benefits or behavioral health services is being reduced from 720 hours to 600 hours within a 12 month period of time. The 12 months will run from October 1 to September 30 of the next year.

BENEFIT/SERVICE	SERVICE DESCRIPTION	SERVICE EXCLUDED FROM PAYMENT
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.	AHCCCS will not cover dental services (including emergency dental services) unless the care needed is a medical or surgical service related to dental (oral) care. Covered dental services for members 21 years of age and older must be related to the treatment of a medical 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 will not pay for services provided by a podiatrist or podiatric surgeon for adults. Contact your health plan for other contracted providers who can perform medically necessary foot and ankle procedures, including reconstructive surgeries.
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 15 visits per contract year (October 1 to September 30 of the following year). Physical therapy to maintain or help achieve a level of function when medically necessary is limited to 15 visits per contract 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.

SERVICES NOT APPROVED BY OUR PLAN – NOTICE OF ACTION

If our plan does not approve care or medicine ordered by your PCP (or other authorized provider) or reduces or terminates a service you are receiving, you will receive a written Notice of Action letter. The Notice of Action letter must be mailed within fourteen (14) calendar days from when the request was received. The notice will explain why this service was denied. You will receive a written notice at least ten (10) days before we reduce, stop or end a service that you have been getting. The notice you receive will tell you how to appeal this decision if you do not agree. You, your authorized representative, or your provider may request an appeal in person, verbally or in writing. It must be done through our Appeals and Grievances Department within sixty (60) days from the date of the Notice of Action.

We will provide you with a written notification of the decision on your appeal within thirty (30) days of filing the appeal.
We will review the request to determine whether the appeal will be an Expedited or Standard appeal. An Expedited Request is when a medically necessary item or procedure is needed within three (3) business days because a Standard Appeal timeframe would seriously jeopardize your life, health or well-being. If an Expedited request is received and does not meet the criteria for an Expedited appeal, the request will be worked as a Standard appeal and you will be notified.

An Expedited appeal must be approved or denied within three (3) business days from the date we receive the request. We will provide you with verbal and written notification within three (3) days of filing the appeal.

You have the right to request an extension to give us information to help us make a decision. We can request an extension for up to fourteen (14) days if there is a need for additional information and if the delay is in your best interest. You will receive written notification of the reason for the extension request.

If you receive a Notice of Action letter that does not tell you what you asked for, what we decided and why, please contact us. We will look at the Notice of Action letter and if needed, will write a new letter that better explains the services and the action taken. If you still do not understand the Notice of Action letter, you have the right to contact AHCCCS Medical Management.

The criteria that decisions are based on are available upon request.

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.

Health Net Access
Attn: Appeals & Grievances Department
PO Box 10341
Van Nuys, CA 91410-0341

Phone: 1-888-788-4408
TTY/TDD: 1-888-788-4872
Fax: 1-855-844-0687

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 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 Action 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 Action 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 appear above.

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 three (3) working days 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) 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.

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 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 to contact you by phone. We will then decide your appeal 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 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 Action 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 Action 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.

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

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 1-602-417-7000. 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 1-602-417-7000. 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.

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!

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 1-602-417-7000.

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.

MEMBER RIGHTS AND RESPONSIBILITIES

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. Members have rights and responsibilities. The following is a description of your rights and responsibilities as a member.

MEMBER RIGHTS

As a member, you have the right to:

- 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
- Be treated fairly regardless of race, religion, color, creed, disability, sexual preference, gender, age, ability to pay
- 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
- Receive information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand the information
- Select a primary care physician (PCP) from Health Net Access's participating PCPs
- 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
- Be free from any restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- Be provided with information about formulating advance directives with your health care providers
- Receive information in a language and format that you understand
- Be provided with information regarding grievance, appeals and request for hearing
- Complain about the managed care organization (Health Net Access)
- 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.
- Amend or correct your medical records as allowed by law
- 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
- Have a list of available PCPs, including those who speak a language other than English.
- 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.
- Request information on the structure and operation of Health Net Access or our subcontractors.

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
- 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.

IMPORTANT INFORMATION: WHAT ELSE DO I NEED TO KNOW?

COORDINATION OF BENEFITS (COB)

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

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

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

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

OR

- The Primary Insurance Paid amount and the AHCCCS Fee for Service Rate, even if the services are provided outside of the network.

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

SPECIAL INFORMATION FOR OUR MEMBERS WHO HAVE MEDICARE COVERAGE:

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

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

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

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

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.

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:

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.

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.

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

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