MARICOPA
HEALTH PLAN
managed by
THE UNIVERSITY OF ARIZONA
HEALTH PLANS

Member Handbook

CUSTOMER CARE

Statewide: 1-800-582-8686 | *TTY/TDD:* 711 | *Website:* www.mhpaz.com

2502 E. University Drive, Suite 125, Phoenix, Arizona 85034

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

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2013 CALENDAR

January

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
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February

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22	23	24	25	26	27	28
29	30	31				

APPOINTMENTS

WHO	DATE	TIME

Take this page with you to your medical appointments.
This will help you and your doctors determine the best care for you.

MY MEDICAL TEAM

TYPE	NAME	PHONE	LOCATION
Primary Care Physician			
Case Manager			
Pharmacy			
Urgent Care			
Other:			

PRESCRIPTIONS

DRUG NAME	REASON TAKEN	DOSE	HOW OFTEN

OVER-THE-COUNTER MEDICINES, VITAMINS & HERBS

DRUG NAME	REASON TAKEN	DOSE	HOW OFTEN

OTHER INFORMATION

Allergies	
Medical Conditions	
Other Insurance	
Eligibility Office & Renewal Date	

Frequently Used Phone Numbers

AHCCCS

Maricopa….....(602) 417-7000

Other Counties 1-800-962-6690

KidsCare

Maricopa….....(602) 417-5437

Other Counties 1-877-764-5437

Community Resources

Department of Economic Security.....(602) 542-9935 or 1-800-352-8401

Social Security.....1-800-772-1213

Pregnancy, Baby AZ & Breastfeeding Hotline..... 1-800-252-5942 ext. 1

WIC (Women, Infants, and Children)..... 1-800-252-5942 ext. 2

Head Start.....1-866-763-6481

(ASHline) Arizona Smokers Helpline.....1-800-556-6222

Tobacco Use Prevention Program.....(602) 372-7272

Regional Behavioral Health Authorities (RBHA)

Community wide Crisis Line 1-800-631-1314

Magellen (Maricopa County) 1-800-564-5465

Arizona Suicide & Crisis Hotline.....1-866-205-5229

Sexual Assault Crisis Hotline 1-866-205-5229

Adult Protective Services .....1-877-SOS-ADULT or 1-877-767-2385

Child Protective Services ..... 1-888-SOS-CHILD or 1-888-767-2445

Drug & Poison 1-800-222-1222

AZ-EIP ..... (602) 532-9960 or 1-888-439-5609

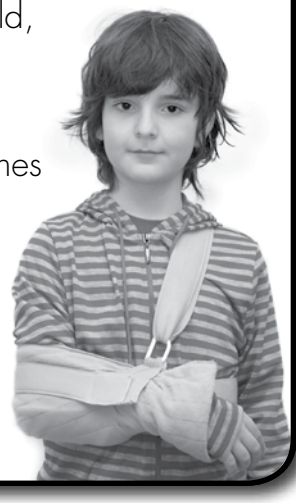
Should you go to the Emergency Room or Urgent Care?

Examples of **Emergency Room Symptoms**

- Extreme shortness of breath
- Fainting
- Poisoning
- Chest pains
- Uncontrolled bleeding
- Seizures

Examples of **Urgent Care Symptoms**

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



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Welcome & Thank You

Welcome and thank you for choosing Maricopa Health Plan (MHP). Maricopa Health Plan is managed by The University of Arizona Health Plans. We are happy to serve you and we look forward to providing you and your family with quality health care services. We ask that you read the Member Handbook so that you understand your health care benefits.

You have a choice of many doctors. Maricopa Integrated Health Systems is part of your MHP list of doctors, medical offices, hospitals, and clinics. MHP doctors take care of you and your family when you are well and when you become sick. Your health care team may include doctors, nurse practitioners and physician assistants. They work as a team to provide your care. We encourage you to make regular, routine medical appointments. These appointments will help keep you healthy.

Our priority is for you to receive the services you and your family need, when you need them. You can visit our website for the most up-to-date information at *www.mhpaz.com*. You can also call Customer Care at 1-800-582-8686. Please call Customer Care if you have any questions or if we help you in anyway.

Thank you for allowing us to be your partner in health and well being!

LANGUAGE INTERPRETATION SERVICES

Maricopa Health Plan is proud to have members with different languages and cultures. As a member of MHP, you have access to a service that offers interpretive services for 150 different languages so that if you need this handbook or any other information in another language other than English, on audiotape, or in American Sign Language, please contact the Customer Care Center at 1-800-582-8686. Please call Customer Care four (4) days before your medical appointment to arrange language interpretive services in time for your appointments. There is no cost for language interpretation services.

VIETNAMESE

Maricopa Health Plan tự hào khi có các thành viên với nhiều ngôn ngữ và văn hóa khác nhau. Là một thành viên của MHP, bạn có quyền truy cập đến dịch vụ cung cấp thông dịch cho 150 thứ ngôn ngữ khác nhau, do vậy nếu bạn cần dịch quyển hướng dẫn này hay bất kỳ thông tin nào sang một ngôn ngữ khác ngoài tiếng Anh, trên băng ghi âm, hay trên Ngôn ngữ Ký hiệu của Mỹ, xin hãy liên hệ với Trung tâm Hỗ trợ Khách hàng theo số 1-800-582-8686. Xin hãy gọi Hỗ trợ Khách hàng 4 ngày trước buổi hẹn khám của bạn để xếp lịch hẹn dịch vụ thông dịch kịp thời cho các buổi hẹn của mình. Các dịch vụ thông dịch ngôn ngữ là miễn phí.

RUSSIAN

Maricopa Health Plan по праву гордится тем, что в число членов программы входят представители разных культур, говорящие на разных языках. Являясь членом MHP, Вы имеете доступ к услуге перевода с и на 150 различных языков, поэтому если Вам необходима информация на ином языке, кроме английского, на аудиокассете или с сурдопереводом на американском языке жестов, пожалуйста, свяжитесь с Отделом обслуживания клиентов по телефону 1-800-582-8686. Если Вы хотите, чтобы при посещении врача с Вами присутствовал переводчик, обратитесь в Отдел обслуживания за 4 дня до визита к врачу. Услуги переводчика предоставляются бесплатно.

ARABIC

تفخر يونيفيرسيتي فاميلي كير (Maricopa Health Plan) بأن بها أعضاءً يتحدثون لغات مختلفة وينتمون إلى ثقافات مختلفة. وبصفتك عضواً فيMHP، فإنه يتاح لك الحصول على خدمة تقدم ترجمة فورية إلى أكثر من 150 لغة مختلفة بحيث إذا رغبت في الحصول على هذا الكتيب أو أية معلومات أخرى بلغة غير الإنجليزية، وعلى شريط تسجيل، أو بلغة الإشارة الأمريكية، يمكنك التفضل بالاتصال بمركز خدمة العملاء على رقم 1-800-582-8686. من فضلك اتصل بمركز خدمة العملاء قبل موعد استشارتك الطبية بـ4 أيام لترتيب خدمات الترجمة الفورية في الوقت المناسب لمواعيد استشارتك. لا توجد أية تكلفة لخدمات الترجمة الفورية.

SOMALI

Maricopa Health Plan waxay ku hanweyn tahay in ay haysato xubno leh luqado iyo dhaqano kala duwan. Ka xubin ahaan MHP, waxaad heli kartaa adeeg bixiya adeegyada tarjumadda 150 luqadood si haddii aad ugu baahato buugyrahan ama macluumaad dheeraad ah luqado kale oo aan ahayn Ingiriisi, cajalad, ama Afka Maraykan ee faraha, fadlan kala xidhiidh Xarunta Daryeelka Macmiilka 1-800-582-8686. Fadlan wac Daryeelka Macmiilka 4 maalmood kahor ballankaaga caafimaadka si aad waqti habboon ugu hesho adeegyada tajumadda luqadda maalinta ballankaaga. Waa bilaash adeegyada tarjumadda luqaddu.

CHINESE-MANDARIN

大学家庭护理计划（MHP）吸引了众多语言不同、文化各异的成员，我们对此非常自豪。作为MHP的成员，您可以享受涵盖150种不同语言的口译服务。如果您需要该手册或其他信息的非英语版本、录音磁带，或需要通过美式手语进行了解，请拨打 1-800-582-8686 联系客户服务中心。请在就诊前4天联系客服中心，以便我们及时安排口译服务。该项服务不收取任何费用。

SPANISH

En Maricopa Health Plan nos sentimos orgullosos de tener miembros de diferentes culturas que hablan diferentes idiomas. Como miembro de MHP, usted tiene acceso a servicios de interpretación en más de 150 idiomas. Si necesita este manual o cualquier otra información en otro idioma que no sea inglés, o en audio video, o en Lenguaje Americano de Señas, comuníquese con el Centro de Servicios para Miembros al Tel. 1-800-582-8686. Llame a Servicios para Miembros cuatro (4) días antes de su cita médica para hacer arreglos para sus servicios de interpretación con anticipación suficiente para sus citas. No hay costo por los servicios de interpretación.

Table of Contents

General Information

Covered Services

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Member Rights

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

General Information

MHP 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. Children ages 0-20 need to have regular checkups every year. Regular screenings will help keep your children healthy.

Terms

You will see the following terms used in this handbook. Here is what they mean:

AHCCCS	Arizona Health Care Cost Containment System
AHCCCSA	Arizona Health Care Cost Containment System Administration
CRS	Children's Rehabilitative Services
DES	Department of Economic Security
EPSDT	Early and Periodic Screening, Diagnosis & Treatment
MCH	Maternal Child Health
MHP	Maricopa Health Plan
NOA	Notice of Action letter
PCP	Primary Care Physician
QMB	Qualified Medicare Beneficiary
RBHA	Regional Behavioral Health Authority
SOBRA	Sixth Omnibus Budget Reconciliation Act
SMI	Seriously Mentally Ill
SSI	Supplemental Security Income
TANF	Temporary Assistance to Needy Families

Key Points for Members

REMEMBER — 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 AHCCCS ID Card.**
2) Call your doctor's office for preventive care or if you have a symptom.
3) Keep your medical appointments.
4) Make sure you have a referral from your doctor or hospital when you need to see a specialist.
5) Follow your doctor's orders.

Role of your Primary Care Physician (PCP)

Your Primary Care Physician (PCP) is your assigned doctor and he/she 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 PCP before you see any other doctor, unless you have an emergency or behavioral health problem. If you are 20 years of age or younger, you can visit a dentist without visiting your PCP first. For more information on emergency room use, please see the section titled "Urgent Care and Emergency Room Use" on page 26.

NOTE: Women can have a Pap or mammogram screening once a year without a referral from their PCP. For members 21 years and older, well visits* are no longer covered. Please see the excluded benefits table on page 22. Please contact Customer Care for more information on Pap smears, mammograms, and colonoscopies.

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

How to Choose or Change a Primary Care Physician (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 help you better with your health care. This relationship is very important in providing you the care you need. You can find a list of MHP doctors on our website at *www.mhpaz.com* or by calling Customer Care.

- If you wish to change your PCP, please call the Customer Care Center for assistance. You can also submit a change request via writing to the address on the cover.
- We encourage you not to change your PCP more than five (5) times a year.
- If you are having problems with your PCP, please call the Customer Care Center. We are here to help you.
- A PCP change can be made effective the same date of the request.
- A listing of MHP doctors and participating pharmacies can be found on our website. Please call the Customer Care Center if you would like to have a copy of the provider listing sent to you at no cost.

How To Make, Change, or Cancel an Appointment

TO MAKE AN APPOINTMENT:

- Call your PCP, dentist, or specialist to schedule your appointment
- Tell the provider's office:
  - Your name
  - Your MHP ID number
  - Your doctor's name
  - Why you need to see this doctor

TO CHANGE AN APPOINTMENT:

- Call your doctor's office at least 24 hours ahead of time
- Tell the doctor's office:
  - Your name
  - Your MHP ID number
  - The date of your appointment
  - Ask to set a new date to see your doctor
  - If needed, change your transportation appointment

TO CANCEL YOUR APPOINTMENT:

- Call your doctor's office 24 hours ahead of time
- Tell the doctor's office:
  - Your name
  - Your MHP ID number
  - Date of your appointment
  - That you want to cancel your appointment
  - If needed, cancel your transportation appointment

If you are unable to contact your doctor's office and need help, please call Customer Care.

WHEN CALLING CUSTOMER CARE, PLEASE HAVE THE FOLLOWING INFORMATION READY:

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

Membership Cards

Once you become eligible for AHCCCS, you will receive a Membership Identification 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 an MHP member and lists important phone numbers and information that your Health Care Provider will need.

Only you are allowed to use your AHCCCS 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 AHCCCS MEMBER 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 the Customer Care Center

If you don't have an AHCCCS ID card or if you lose your card, call AHCCCS at (602) 417-4000 or 1-800-654-8713 to get a new one.

The Customer Care Center

The Customer Care Center is staffed by English and Spanish speakers who are here to help you get the medical care you need. You can call the Customer Care Center at 1-800-582-8686, or if you are a TTY user you can contact the Arizona Relay System at 711. If you speak another language other than English or Spanish, call Customer Care and we will help get an interpreter to assist with the phone call.

SOME OF THE WAYS WE 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 understand MHP
- 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 Sign 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 Customer Care immediately. We will refer you to a Case Manager to make sure you are getting the care you need.

Protecting Your Health Information – Member Verification

When you call Customer Care, 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:

ID number, birth date, address, phone number, and name.

AHCCCS ALSO HAS ANOTHER SAFETY MEASURE TO PROTECT YOUR HEALTH INFORMATION. IF YOU HAVE A STATE OF ARIZONA DRIVER'S LICENSE OR STATE ISSUED ID, AHCCCS WILL GET YOUR PICTURE FROM THE ARIZONA DEPARTMENT OF MOTOR VEHICLE DIVISION (MVD). THE SAME PICTURE WILL BE PLACED ON YOUR AHCCCS ELIGIBILITY VERIFICATION SCREEN. PROVIDERS THAT VERIFY YOUR ELIGIBILITY THROUGH AHCCCS ON-LINE WILL BE ABLE TO VIEW YOUR ELIGIBILITY AND SEE YOUR PICTURE.

Annual Enrollment Choice (AEC)

On your AHCCCS enrollment anniversary date every year, you may change your health plan. AHCCCS will send you information two months before your anniversary date. If you are thinking about leaving MHP, please call Customer Care so we can help solve any problems you may have. MHP values your membership.

Authorized Contact

AN AUTHORIZED CONTACT IS A PERSON YOU TRUST AND HAVE GIVEN PERMISSION TO INQUIRE OR MAKE CHANGES ABOUT YOUR ACCOUNT. YOU MAKE THIS OFFICIAL BY PROPERLY NOTIFYING THE HEALTH PLAN OF PEOPLE YOU GIVE PERMISSION TO. CALL CUSTOMER CARE FOR MORE INFORMATION.

Customer Care only gives your medical information to people you trust and have given permission to. If a friend or family member calls, and we **do not** have them listed as an Authorized Contact, we will not give them information about your account. We do this to protect your medical information. If a friend or family member calls and we **do** have permission, we will verify their information and yours to protect your account. Then we can answer any questions your friend or family member may have.

If you would like to add someone to your account, please call us or write us at the address on the cover. We will add this person and give them permission, for up to a year, to call and ask questions about your medical

IF YOUR ADDRESS OR PHONE NUMBER CHANGES, IT IS VERY IMPORTANT THAT YOU REPORT IT.

- Call Customer Care with your new address and phone number.
- Call your local D.E.S. eligibility office with your new address and phone number.
- KidsCare members can call 1-800-962-6690 or (602) 417-7000.

information. You can remove an Authorized Contact at any time. Other documents you can mail to add an Authorized Contact includes: Notarized letters, Court guardianship papers, Court Custody papers, or a Power of Attorney.

HOW DO YOU ADD AN AUTHORIZED CONTACT TO YOUR ACCOUNT?

- Write a letter to Customer Care letting them know who you are, and who you give permission to. The letter must include your name, identification number, and date of birth as well as the name, address, phone number, and date of birth of the person you give permission. The letter must also state that you give permission for this person to access your medical information and make changes on your behalf.
- Or, just use the form to the right to give permission.

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 MHP members should first contact the Department of Economic Security at 1-800-352-8401 or (602) 542-9935 or your local Social Security Eligibility office at 1-800-772-1213 to renew coverage. You can call MHP Customer Care if you have questions or need assistance with

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AUTHORIZED CONTACT FORM

Fax the completed form to Customer Care to (520) 874-3434

Or mail it to: MHP, Attention Customer Care Center
2701 E. Elvira Road, Tucson, AZ 85756

I, _____,
(member name)

ID #_____, am giving written permission to
(member ID#)

_____,
(Friend, family, other name)

so that he/she can have access to my medical information with my health plan. I am also including information about this person so the health plan can verify this person when they speak on my behalf.

Name of Authorized Contact:

_____

Date of Birth:_____

Relationship: ❑ Friend ❑ Family ❑ Other

Address:_____

_____

Phone Number: _____

❑ I give this person permission to access **my medical information**
(Example: The name of my PCP or the status of a referral.)

❑ I give this person permission **to make changes** on my behalf.
(Example: Changing my PCP or setting up transportation.)

_____
Signature of Member Date

_____
Signature of Authorized Contact Date

the renewal process. We are happy to answer any questions you might have.

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

- Stop getting TANF
- Stop getting food stamps
- Stop getting SOBRA Family Planning Extension Services
- 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 (602) 417-7000. You can call Customer Care to get your renewal date.

Health Plan Changes

There are certain reasons why you may change your health plan outside of your normal Annual Enrollment Choice (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 (602) 417-7000.

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

What to Do when your Family Size Changes

If there is a change in family size due to birth, death, marriage, adoption or divorce, you must call your eligibility office (DES or Social Security) to make sure all family members are covered by MHP.

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.

Moving

WHAT IF YOU ARE MOVING AWAY FROM THE SERVICE AREA?

If you move out of the United States, the state of Arizona, or out of your county, your current plan will no longer be valid. Before you move, call Customer Care to update your address. We can often update your address with the AHCCCS eligibility office.

Other places you should notify include:

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

Call Customer Care if you have questions about your enrollment or call AHCCCS at 1-800-654-8713 or (602) 417-7000.

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 Customer Care if you have any questions about your enrollment or call AHCCCS at 1-800-654-8713.

Cultural Competency

We value the many people who live in the areas we serve. We understand that there are many different lifestyles and ethnic backgrounds of people in Maricopa county. MHP knows 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 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

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 MHP Customer Care Center.

YOU COULD LOSE YOUR CARE BY AHCCCS IF YOU DO NOT TELL THESE OFFICES YOU ARE MOVING.

needs. MHP provides language interpretive services for members at no cost to you. If you cannot speak to your provider because of a language barrier, please contact Customer Care. 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 Customer Care. 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 the people and services that make up MHP.

CALL CUSTOMER CARE AND LET US KNOW ABOUT YOUR HERITAGE, CULTURE, & HEALTH PRACTICES. WE CAN HELP YOU FIND DOCTORS WHO UNDERSTAND YOUR VALUES. WE CAN ALSO GIVE YOU INFORMATION ABOUT HEALTH CONCERNS YOU MAY HAVE.

Ask Me 3

MHP offers an exciting program called Ask Me 3. It will help you talk with your doctor. You can ask your doctor any questions about your health. At times, you may not know what questions to ask. If this is the case, ask these 3 questions from the 'Ask Me 3' Program:

Use the Ask Me 3 questions to better understand your health:

1) What is my main problem?
2) What do I need to do?
3) Why is it important for me to do this?

Let your PCP, nurse, pharmacist, or other provider know if you still don't understand what you need to do.

Like all of us, doctors have busy schedules. Yet your doctor wants you to know:

- All you can about your condition.
- Why this is important for your health.
- Steps to take to keep your condition under control.

Partnership for Clear Health Communication

Please call Customer Care if you would like to talk to someone about Ask Me 3.

HOW CAN YOUR DOCTOR HELP YOU STAY HEALTHY?

- Make sure children ages 0 – 20 receive their annual well-exams and immunizations.
- Adults ages 21 and older should visit their PCP when a symptom or sickness develops.
- Schedule preventative exams such as Pap, Mammogram, and Cancer screening once a year. Colonoscopies can be scheduled once every five to ten years.
- 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.

Covered Services (including Dental and Behavioral Health)

As a member of MHP, 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 he/she 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 services:

- Emergency Services
- Behavioral Health issues
- OB/GYN services
- Dental services for children ages 0-20

Please remember that KidsCare Members have benefits through age 18.

The care listed below will be covered with MHP. Call or write MHP Customer Care for more facts about these services:

- Ambulance for emergency care
- Behavioral Health Care
- Care while you are pregnant
- Case management
- Checkups for children*, pregnant women, QMB, and SMI members
- 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 through screenings, diagnosis and medically necessary treatments for members 21 years of age or older
- Hospice care
- Hospital care
- Lab work and x-rays
- Medical tests
- Medically needed foot care not performed by a podiatrist
- Medicine from the approved drug list, the MHP Drug Formulary
- PCP office visits for children*, QMB, SMI, or when an adult has a symptom or sickness
- Preventative and routine gynecological services for female members (no referral needed)
- Rides to health care visits
- Second opinions: 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 arrange for a second opinion outside the network at no cost to you.
- Supplies and equipment, including MHP Drug Formulary diabetic testing equipment and supplies
- Well-child checkups including dental, hearing, shots and vision care*

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

Your PCP may want you to see a specialist or get special services. He/ she will arrange for the special care listed below. Some of these may require prior authorization from MHP.

- Diet and health teaching
- Home health care
- Organ transplants
- Skilled nursing home care
- Rehabilitation services like physical therapy, occupational therapy, or speech therapy
- Specialist care
- Social Services

In special cases you may be able to get services outside of your service area. Please contact Customer Care if you would like more information.

Approval and Denial Process:

Some of the medical services listed below may need prior approval by MHP. If they do, your provider will arrange for authorization for these services. MHP must review these authorization requests before you can get the service.

Your PCP's office will let you know when authorization is

Medically necessary means 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.

PRIOR AUTHORIZATION MEANS YOUR DOCTOR HAS REQUESTED PERMISSION FOR YOU TO GET A SPECIAL SERVICE. MHP MUST APPROVE THESE REQUESTS BEFORE THE DELIVERY OF SERVICES. PRIOR AUTHORIZATION IS APPROVED BASED ON A REVIEW OF MEDICAL NEED.

obtained. You can also call Customer Care to find out the status of the request.

MHP 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. For further questions, call Customer Care. If you have a question about the denial and need help, please call Customer Care or write to us at the address listed on the cover of this handbook. Please see page 28 for more information about filing an appeal about a denied authorization.

PLEASE REMEMBER: Some of the services listed below must be approved in advance by MHP. MHP will only pay for the services that are ordered by your PCP and have been approved by MHP. In order for these services to be covered, they must be medically necessary.

Home and Community Based Services (HCBS)

There may be a time when your PCP decides that you need services that are usually provided in a hospital or a nursing home. Instead of these facilities, your PCP may request an assisted living facility or Home and Community Based Services (HCBS) to care for you. These arrangements are covered by your plan for a maximum of 90 days per year, and must be approved by MHP.

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

Member Resource Center

The Member Resource Center is a place members can get personal help with benefit questions, billing questions, scheduling appointments, community resources, and more! The Member Resource Center is located at the South Central Family Health Center. You can schedule an appointment, or walk right in. Visit us at:

33 W. Tamarisk
Phoenix, AZ 85041
(602) 344-6454

Case Management

Case management is a benefit MHP offers at no cost to you. Our goal is to help you be healthy through education and your own health care planning. A staff of nurses will help you and/or a family member get the health care you need, understand your medicines and work with you and your PCP to get any other services you need to keep you healthy. For more information please call Case Management at 1-877-874-3933.

Disease Management

Disease Management is another service offered at no cost to MHP members. If you have a health problem such as diabetes or asthma, or if you are looking for ways to stay healthy, our Disease Managers are here to help you. Please call Case Management at 1-877-874-3933 for more information.

Tobacco Education and Prevention

The MHP Tobacco Cessation Program offers a number of nicotine replacement products (patches, lozenges, gum) and medications to help you quit tobacco. When you and your doctor decide which product is best for you, a twelve week supply is available by prescription every six months as necessary. Only one product can be selected at a time. Members also have free telephone support from the Arizona Smokers Hotline (ASHline) sponsored by the Arizona Department of Health Services and Prevention Program (ADHS-TEPP). ASHline can help you at no cost by setting a quit date and giving you support. If you would like more information about quitting tobacco, please call the ASHLine at 1-800-556-6222, visit their website at *www.ashline.org*, or call Customer Care.

Dental Care

- All dental health checkups, cleanings and treatments are covered for health plan members ages 20 and younger.
- Children do not need to be referred by his/her PCP to see a dentist.

At 12 months of age children should begin to see a dentist for a checkup every six (6) months. MHP sends dental checkup reminder postcards. 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 for your child to go to the dentist two times every year.

Look in the Plan's Provider Directory to choose a dental clinic near you or call Customer Care for help scheduling a visit.

Use these guidelines for scheduling appointments for your child.

- Emergency dental appointments – same day appointments; for extreme pain and dental emergencies
- Urgent dental appointments – within three (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 AHCCCS ID card with you to the dental appointment

Pregnant, QMB, SMI, and transplant members may also visit a dentist in our network for emergency services.

Any member age 21 years and older can only receive emergency dental services if you have a need for care immediately, like a bad infection in your mouth or pain in your teeth or jaw. Pre-transplantation members can also get treatment for oral infections, oral disease, periodontal disease, medically necessary extractions, and simple restorations like a filling or crown. Call Customer Care to see if you have been approved for your transplant before you seek dental care.

Pharmacy Services

PRESCRIPTIONS

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

If the medicine your doctor feels you need is not on our list and you can't take any other medication except the one prescribed, he/she may request prior authorization from MHP.

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, MHP will only pay the co-pays if the drug is also on the MHP drug list.

WHAT YOU NEED TO KNOW ABOUT YOUR PRESCRIPTION

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

Carefully read the drug information the pharmacy will give you when you fill your prescription. It will explain what your medicine is for and possible side effects. If you do not understand how to take your medicine or why you should take it; ask to speak to the pharmacist.

WHAT HAS CHANGED FOR DUAL-ELIGIBLE MEMBERS (MEDICARE DRUG COVERAGE FOR BARBITURATES AND BENZODIAZEPINES)

AHCCCS covers drugs which are medically necessary, cost effective and allowed by federal and state law.

For AHCCCS recipients with Medicare, AHCCCS does NOT pay for any drugs paid by Medicare, or for the cost-sharing (coinsurance, deductibles and copayments) for drugs available through Medicare Part D even if the member chooses not to enroll in the Part D plan.

Beginning January 1, 2013, AHCCCS **will no longer pay** for barbiturates to treat epilepsy, cancer, or mental health problems or any benzodiazepines for members with Medicare.

This is because federal law requires Medicare to begin paying for these drugs starting January 1, 2013. Some of the common names for benzodiazepines and barbiturates are:

GENERIC NAME	BRAND NAME
Alprazolam	Xanax
Diazepam	Valium
Lorazepam	Ativan
Clorazepate Dipotassium	Tranxene
Clordiazepoxide Hydrochloride	Librium
Clonazepam	Klonopin
Oxazepam	Serax
Temazepam	Restoril
Flurazepam	Dalmane
Phenobarbital	Phenobarbital
Mebaral	Mephobarbital

AHCCCS will still pay for barbiturates for Medicare members that are **NOT** used to treat epilepsy, cancer, or mental health problems even if it is after January 1, 2013.

For information about copayments for drugs that are covered by AHCCCS, please read the section about copayments on page 20.

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 one 30-day refill at a time.

If your doctor has not ordered refills, you must call him/her **AT LEAST FIVE (5) DAYS BEFORE**

BEFORE YOU LEAVE THE OFFICE, ASK THESE QUESTIONS:

- Why am I taking this medication? What is it supposed to do for me?
- How should the medicine be taken? When? For how many days?
- What are the side effects or allergic reactions of the medicine and what should I do if a side effect happens?
- What will happen if I don't take this medication?

your medication runs out. Talk tohim/her about getting a refill. The doctor may want to see you before giving you a refill.

WHAT SHOULD I DO IF THE PHARMACY DENIES MY PRESCRIPTION?

Call Customer Care and we can help find out why your prescription is not approved to fill. 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 Formulary – our list of covered drugs. If the pharmacy turns you away or will not fill your prescription, ask if you and/or the pharmacist can call Customer Care together to find what is happening. We will work with you and the pharmacy to find the best options for you.

For pharmacy issues after hours or on holidays, please contact Customer Care at 1-800-582-8686

Behavioral Health Services

MHP members are eligible for behavioral health services (except SOBRA Family Planning Members). Behavioral Health Providers can help you with personal problems that may affect you and your family. Examples of situations when behavioral health services can help are when you are feeling anxious or depressed more days than not; when you have experienced a trauma, such as a major accident, or you were the victim of a crime, or physical, emotional or sexual abuse; when you have lost a loved one; or if you are in a domestic violence situation. If you think you or your family member may have problems with a mental illness or substance abuse, behavioral health services can be very helpful. You do not need a referral from your PCP to receive behavioral health services.

Your AHCCCS card has the phone number of the provider (Regional Behavioral Health Authority or RBHA) that will give you behavioral health or substance abuse services. You are assigned to a provider (RBHA) based on where you live. The provider (RBHA) will pay for most behavioral health services including most prescriptions for behavioral health conditions.

If you have questions or need help getting behavioral health services, please call the number on your card.

BEHAVIORAL HEALTH EMERGENCIES

A behavioral health emergency includes any situation where, because of your mood or thinking, you believe you might hurt yourself or someone else. You should call 911 immediately and ask them to help determine the best course of action for you in these situations. Behavioral health emergencies also occur when someone's thinking changes rapidly to the point where the person is not able to recognize reality from fantasy. Sometimes the person does not realize what is happening and may not want help, but help is available through 911 or a local emergency room.

For behavioral health emergencies, call 911. For behavioral health crisis assistance, call Community Wide Crisis Line at 1-800-631-1314

MHP can make referrals and help enroll you to receive behavioral health services. For non-emergency behavioral health services call any of the following people or organizations to find out where to go or who to call for help with your situation:

- Call Customer Care during business hours and ask for assistance with a behavioral health referral or to speak with a Behavioral Health Case Manager
- Call your PCP's office

Behavioral health benefits are provided through your Regional Behavioral Health Authority (RBHA). For Maricopa County the RBHA is Magellan of Arizona; you may call them at 800-564-5465 and ask them to help you with a referral.

BEHAVIORAL HEALTH SERVICES THAT YOU MAY BE ELIGIBLE FOR INCLUDE:

a. Behavior Management (personal care, family support/ home care training, peer support)
b. Behavioral Health Case Management Services
c. Behavioral Health Nursing Services
d. Emergency Behavioral Health Care

ALL AHCCCS ELIGIBLE MEMBERS (EXCEPT SOBRA FAMILY PLANNING MEMBERS) ARE AUTOMATICALLY ENROLLED WITH A REGIONAL BEHAVIORAL HEALTH AUTHORITY (RBHA). IF YOU NEED ASSISTANCE IDENTIFYING YOUR ASSIGNED RBHA, PLEASE CONTACT CUSTOMER CARE.

IF YOU HAVE A SERIOUS MENTAL ILLNESS OR YOU WANT COUNSELING, BEHAVIORAL HEALTH BENEFITS ARE PROVIDED THROUGH YOUR REGIONAL BEHAVIORAL HEALTH AUTHORITY (RBHA).

- Call Magellan of Arizona Health Services at 1-800-564-5465
- Call Magellan of Arizona Crisis Line 1-800-631-1314
- Call your PCP

e. Emergency and Non-Emergency Transportation
f. Evaluation and Assessment
g. Individual, Group and Family Therapy and Counseling
h. Inpatient Hospital Services
i. Non-Hospital Inpatient Psychiatric Facilities Services (Level I residential treatment centers and sub-acute facilities)
j. Laboratory and Radiology Services for Psychotropic Medication Regulation and Diagnosis
k. Opioid Agonist Treatment
l. Partial Care (supervised day program, therapeutic day program and medical day program)
m. Psychosocial Rehabilitation (living skills training; health promotion; supportive employment services)
n. Psychotropic Medication
o. Psychotropic Medication Adjustment and Monitoring
p. Respite Care (limited to 600 hours per contract year – October 1 through September 30)
q. Rural Substance Abuse Transitional Agency Services
r. Screening
s. Home Care Training to Home Care Client

Your PCP will be able to prescribe for you and monitor medication if you have some types of depression, anxiety, or attention deficit hyperactivity disorder (ADHD).

The Customer Care Center can help you in finding your RBHA service provider.

BEHAVIORAL HEALTH TRANSPORTATION

If you are receiving behavioral health services through a behavioral health service provider, please call the behavioral health service provider if you need help getting to your appointment.

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.

Women Health Screening

Woman should get preventative screenings each year. Preventative services include, but are not limited to, screening services such as cervical cancer screening including Pap smear, mammograms, colorectal cancer, and screening for sexually transmitted infections.

Female members under the age of 21 years may have direct access to preventive and well care services from a gynecologist within the Contractor's network without a referral from a primary care provider.

Female members, 21 years of age and over, may have direct access to a gynecologist within the Contractor's network without a referral from a primary care provider. Preventive services such as cervical cancer screening or referral for a mammogram are covered. A well woman exam is not a covered benefit. Please see the excluded benefits table on page 22. Please contact Customer Care for more information on Pap smears, mammograms, and colonoscopies.

A Pap smear tests for early stages of cervical cancer.

A mammogram tests for breast cancer.

MHP 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. 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 co-payment 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

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 Pregnancy Termination Section
- Hysterectomies if done for family planning only

SOBRA Family Planning Extension Program

If you are on SOBRA Family Planning Extension Program (FPEP) and became eligible for AHCCCS because you became pregnant,

you will lose the medical benefit following your post partum visit. You will be eligible for the SOBRA FPEP for up to 24 months. This program offers many of the same services as those above. With the SOBRA FPEP program, your doctor can screen you for an STD but must refer you to a no or low cost primary care for treatment. You will be provided no or low cost primary care referrals by your doctor and the health plan prior to losing your medical benefit and changing to SOBRA FPEP. When you lose your SOBRA FPEP benefits you can access at no cost, low cost family planning services from providers as well as primary care services.The following is a list of no or low cost primary care services.

AVONDALE

Maricopa Integrated Health Services
Avondale Family Health Center
950 E. Van Buren
Avondale, AZ 85323
(623) 344-6800

BUCKEYE

Buckeye Family Care Center
306 E. Monroe
Buckeye, AZ 85326
(623) 386-4814

CHANDLER

Grand Canyon Family Medicine
Robert Tognacci, DO
3960 E. Riggs Rd. #1
Chandler, AZ 85297
(480) 786-4441

Maricopa Integrated Health Services
Chandler Family Health Center
811 S. Hamilton Ave.
Chandler, AZ 85225
(480) 344-6100

EL MIRAGE

Maricopa Integrated Health Services
El Mirage Family Health Center
12428 W. Thunderbird Rd.
El Mirage, AZ 85335
(623) 344-6500

GILA BEND

Adelante Health Care Center
100 N. Gila Ave.
Gila Bend, AZ 85337
(602) 241-0909

GLENDALE

Maricopa Integrated Health Services
Glendale Family Health Center
5141 W. Lamar Rd.
Glendale, AZ 85301
(623) 344-6700

GUADALUPE

Maricopa Integrated Health Services
Guadalupe Family Health Center
5825 E. Calle Guadalupe
Guadalupe, AZ 85283
(480) 344-6000

MESA

Maricopa Integrated Health Services
Mesa Family Health Center
59 S. Hibbert
Mesa, AZ 85210
(480) 344-6200

Adelante Health Care
2204 Dobson Rd. #101
Mesa, AZ 85202
(480) 491-6235

PHOENIX

Maricopa Integrated Health Services
Comprehensive Healthcare Center
2525 E. Roosevelt St.
Phoenix, AZ 85008
(602) 344-1015

Maricopa Integrated Health Services
Maryvale Family Health Center
4011 N. 51st Ave.
Phoenix, AZ 85031
(623) 344-6900

Maricopa Integrated Health Services
McDowell Family Health Center
1144 E. McDowell #300
Phoenix, AZ 85016
(602) 344-6550

Maricopa Integrated Health Services
Comprehensive Healthcare Center
2525 E. Roosevelt St.
Phoenix, AZ 85008
(602) 344-1015

Maricopa Integrated Health Services
7th Avenue Family Health Center
1205 S. 7th Ave.
Phoenix, AZ 85007
(602) 344-6600

Maricopa Integrated Health Services
South Central Family Health Center
33 W. Tamarisk Ave.
Phoenix, AZ 85041
(602) 344-6400

Maricopa Integrated Health Services
Sunnyslope Family Health Center
934 W. Hatcher Rd.
Phoenix, AZ 85021
(602) 344-6300

Glendale Family Healthcare
7725 N. 43rd Ave. #510
Phoenix, AZ 85051
(623) 537-9698

Maricopa County Department of Health
1645 E. Roosevelt St.
Phoenix, AZ 85006
(602) 506-6909

Maricopa County Health Care for the Homeless
220 S. 12th Ave.
Phoenix, AZ 85007
(602) 372-2100
**Must be homeless to use services*

SUN CITY WEST

Adelante Women's Health Care
14300 W. Granite Valley Dr. #2A
Sun City West, AZ 85375
(623) 544-3214

SURPRISE

Tidwell Family Care Center
16560 N. Dysart Rd.
Surprise, AZ 85374
(623) 546-2294

WICKENBURG
Wickenburg Family Care Center
811 N. Tegner #113
Wickenburg, AZ 85390
(928) 684-9555

Maternity Care

MATERNITY CARE DEFINITIONS

HIGH-RISK PREGNANCY is a pregnancy in which the mother, fetus, or newborn is anticipated to be, at increased risk for morbidity or mortality before or after delivery. High risk is determined with the Medical Insurance Company of Arizona (MICA) or American College of Obstetricians and Gynecologists (ACOG) standardized medical risk assessment tool.

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

MATERNITY CARE includes medically necessary preconception counseling, identification of pregnancy, prenatal care, labor and delivery services and postpartum care.

MATERNITY CARE COORDINATION consists of the following maternity care related activities: determining the member's medical or medical/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; monitoring to ensure the services are received and revising the plan of care as appropriate.

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

POSTPARTUM CARE is the health care provided up to sixty (60) days post delivery. Family planning services are included if provided by a physician or practitioner.

PRECONCEPTION 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.

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

a. Early and continuous risk assessment
b. Health promotion; and
c. Medical monitoring, intervention and follow-up.

We want to help you have a strong, healthy baby. The first step toward having a healthy baby is to take care of yourself during pregnancy. In order for us to help you, it is VERY IMPORTANT that you see a maternity provider early in your pregnancy. Call Customer Care immediately if you experience any delay in getting prenatal care of any kind. If you do not already have a maternity care provider, please contact Customer Care for assistance in choosing a provider. You may choose from any of our contracted maternity providers. If you have begun care with a non-contracted maternity provider it may be possible to have special authorization to insure you receive continuous care with that provider. If you are currently under the care of a non-contracted network provider, you can request to change health plans to ensure continuity of care during your pregnancy.

Pregnant MHP women must plan to give birth at any contracted hospital listed in the network directory. If you experience an emergency during pregnancy, go to the nearest hospital.

If your pregnancy is high-risk, MHP offers OB case management to our members at no cost to you. Our case management staff is specially trained to help you through your pregnancy and after you deliver. They are here to answer questions and help you with any appointments or referrals you might need. If you have any concerns or would like to talk to one of our case managers, please call 1-877-874-3933.

Call Customer Care if you need help choosing a midwife or a doctor or if you need help with a ride to your appointment.

Please call your provider to schedule your first appointment.

Your provider will offer you the following important services while you are pregnant:

- Checkups (including blood pressure check, monitor weight gain, check baby's movement and growth and listen to baby's heartbeat)
- Tests you may need, including lab tests
- Check for infections, including sexually transmitted diseases and HIV/AIDS. NOTE: Confidential counseling is available to those members who test positive.
- Prenatal vitamins
- The delivery of your baby
- Follow-up care after your baby is born

You will be given important information on:

- Having a healthy baby by eating right, exercising and rest

- Things to do or not to do while pregnant
- Normal changes to expect during pregnancy
- Preparing for the birth of your baby
- Childbirth classes
- Preparing for the care of your baby
- Family planning (with the exception of abortions and abortion counseling)

Let us help you get the health care you need to have a healthy baby!

Prenatal Care

When you are pregnant, it is important to get care early and often from a doctor. Doctor visits while pregnant help protect your baby and help you have a healthy baby. If you need help scheduling an appointment with a doctor, please call the Maternal Child Health OB Case Manager by calling Customer Care at 1-800-582-8686, extension 8355.

Members who have a high risk or problem pregnancy can get case management help from MHP. Please contact Customer Care if you need help with your pregnancy.

If you think you are pregnant call your doctor (PCP) for a test.

If you are pregnant, your doctor must see you within:

- Fourteen (14) days if you are in your first trimester (0 month – 3 months pregnant)
- Seven (7) days if you are in your second trimester (3 months – 6 months pregnant)
- Three (3) days if you are in your third trimester (6 months – 9 months pregnant)
- Three (3) days if your pregnancy is high-risk or immediately if it is an emergency (At any time in the pregnancy)

If you experience difficulty getting an appointment in these time frames, call Customer Care and we will work with our Maternal Child Health Department to assist you in getting a timely appointment.

DURING YOUR PREGNANCY:

- See your doctor for a checkup each month. These visits may be more often if needed. Checkups will help find any health problems early for you and your unborn baby.
- **Do not drink alcohol, use drugs or smoke while pregnant.**
- Eat healthy foods.
- Voluntary prenatal HIV testing is available. You will get counseling if the HIV test is positive. Please ask your PCP about this test.

AFTER YOUR PREGNANCY:

It is very important to make and keep your postpartum visit. Your doctor will check to make sure you are healing properly, talk to you about postpartum depression and help you with family planning issues. You should see your maternity provider within six (6) weeks of having your baby.

Women, Infants and Children (WIC)

As a member of MHP, you may be eligible for the 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 and Periodic Screening, Diagnosis and Treatment (EPSDT)*

MHP wants 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.

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

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 behavioral help, talk to your PCP.

The Well-child* program includes:

A. Checkups
- A complete unclothed physical exam
- Developmental/behavioral screenings
- Growth measurements
- Nutrition information
- Oral health screening
- Education about healthy living
- Immunizations – Documentation of all immunizations is required
- TB (Tuberculosis) Screening

B. Tests
- Eye test and glasses/ contacts, if needed
- Hearing test and hearing aid(s), if needed
- Lab tests (including lead screening tests)

C. Services (including, but not limited to)
- Case management
- Chiropractic care if your PCP orders this service and under certain conditions
- Care by specialists, if needed

D. Medicines listed in the MHP Drug Formulary

E. Special medical foods when medically necessary

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:
- Newborn
- 2-4 days old
- 1 month old
- 2 months old
- 4 months old
- 6 months old
- 9 months old
- 12 months old
- 15 months old
- 18 months old
- 24 months old
- Yearly from age 3 to age 21, excluding ages 7 and 9

MHP 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 synonymous with EPSDT.*

Children with Special Health Care Needs

With an approved Prior Authorization, MHP 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. MHP will help children with Special Health Care Needs receive additional help with services that may be provided by Children's Rehabilitative Services (CRS). If you have questions about this benefit, please call the Maternal Child Health Program at 1-877-874-3933.

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 the Maternal Child Health Program at 1-877-874-3933.

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

Parental Evaluation of Developmental Status (PEDS) Tool

If your child was in a neonatal intensive care unit (NICU) after birth, your PCP should use the PEDS tool at your child's EPSDT* visit. The PEDS tool checks growth and development for children that may have been born early or were sick when they were born. If your child was in a NICU, talk to your provider about the PEDS tool.

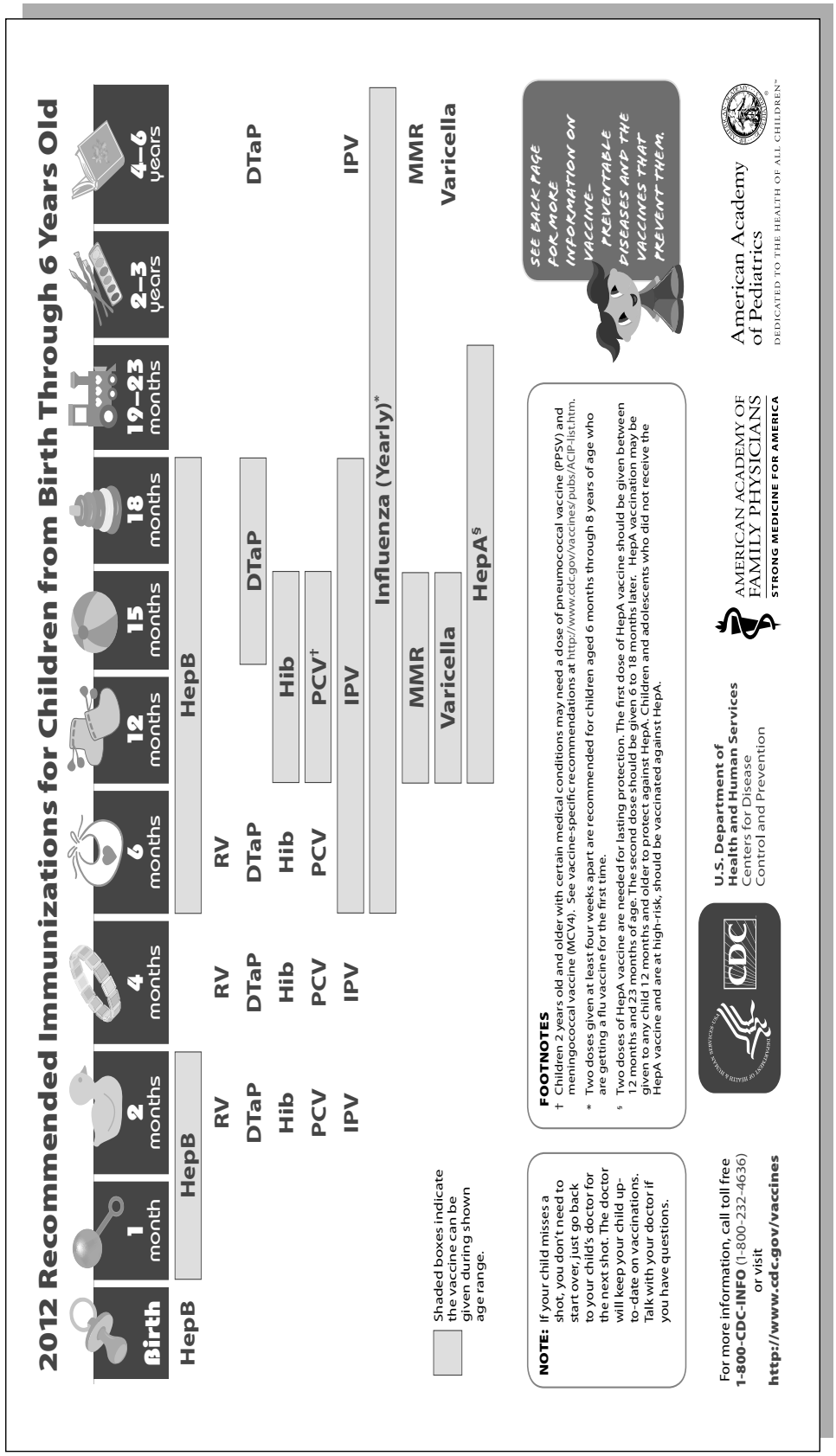
**A well child visit/check is synonymous with EPSDT.*

Additional Community Resources

Please visit the following website link to find out more information that can help you and your family stay healthy:

www.MyAHCCCS.com

Please use this grid below to help you schedule immunizations for children.



Vaccine-Preventable Diseases and the Vaccines that Prevent Them

Disease	Vaccine	Disease spread by	Disease symptoms	Disease complications
Chickenpox	Varicella vaccine protects against chickenpox.	Air, direct contact	Rash, tiredness, headache, fever	Infected blisters, bleeding disorders, encephalitis (brain swelling), pneumonia (infection in the lungs)
Diphtheria	DTaP* vaccine protects against diphtheria.	Air, direct contact	Sore throat, mild fever, weakness, swollen glands in neck	Swelling of the heart muscle, heart failure, coma, paralysis, death
Hib	Hib vaccine protects against *Haemophilus influenzae* type b.	Air, direct contact	May be no symptoms unless bacteria enter the blood	Meningitis (infection of the covering around the brain and spinal cord), mental retardation, epiglottis (life-threatening infection that can block the windpipe and lead to serious breathing problems) and pneumonia (infection in the lungs), death
HepA	HepA vaccine protects against hepatitis A.	Personal contact, contaminated food or water	May be no symptoms, fever, stomach pain, loss of appetite, fatigue, vomiting, jaundice (yellowing of skin and eyes), dark urine	Liver failure
HepB	HepB vaccine protects against hepatitis B.	Contact with blood or body fluids	May be no symptoms, fever, headache, weakness, vomiting, jaundice (yellowing of skin and eyes), joint pain	Chronic liver infection, liver failure, liver cancer
Flu	Flu vaccine protects against influenza.	Air, direct contact	Fever, muscle pain, sore throat, cough, extreme fatigue	Pneumonia (infection in the lungs)
Measles	MMR** vaccine protects against measles.	Air, direct contact	Rash, fever, cough, runny nose, pinkeye	Encephalitis (brain swelling), pneumonia (infection in the lungs), death
Mumps	MMR**vaccine protects against mumps.	Air, direct contact	Swollen salivary glands (under the jaw), fever, headache, tiredness, muscle pain	Meningitis (infection of the covering around the brain and spinal cord) , encephalitis (brain swelling), inflammation of testicles or ovaries, deafness
Pertussis	DTaP* vaccine protects against pertussis (whooping cough).	Air, direct contact	Severe cough, runny nose, apnea (a pause in breathing in infants)	Pneumonia (infection in the lungs), death
Polio	IPV vaccine protects against polio.	Through the mouth	May be no symptoms, sore throat, fever, nausea, headache	Paralysis, death
Pneumococcal	PCV vaccine protects against pneumococcus.	Air, direct contact	May be no symptoms, pneumonia (infection in the lungs)	Bacteremia (blood infection), meningitis (infection of the covering around the brain and spinal cord), death
Rotavirus	RV vaccine protects against rotavirus.	Through the mouth	Diarrhea, fever, vomiting	Severe diarrhea, dehydration
Rubella	MMR** vaccine protects against rubella.	Air, direct contact	Children infected with rubella virus sometimes have a rash, fever, and swollen lymph nodes.	Very serious in pregnant women—can lead to miscarriage, stillbirth, premature delivery, and birth defects
Tetanus	DTaP* vaccine protects against tetanus.	Exposure through cuts in skin	Stiffness in neck and abdominal muscles, difficulty swallowing, muscle spasms, fever	Broken bones, breathing difficulty, death

* DTaP is a combination vaccine that protects against diphtheria, tetanus, and pertussis.
** MMR is a combination vaccine that protects against measles, mumps, and rubella.

Last updated on 02/01/2012 • *CS229912-B*

2012 Recommended Immunizations for Children from 7 Through 18 Years Old

7–10 YEARS	11-12 YEARS	13-18 YEARS
Tdap [1]	Tetanus, Diphtheria, Pertussis (Tdap) Vaccine	Tdap
	Human Papillomavirus (HPV) Vaccine (3 Doses)[2]	HPV
MCV4	Meningococcal Conjugate Vaccine (MCV4) Dose 1[3]	MCV4 Dose 1[3] / Booster at age 16 years
Influenza (Yearly)[4]		
Pneumococcal Vaccine[5]		
Hepatitis A (HepA) Vaccine Series[6]		
Hepatitis B (HepB) Vaccine Series		
Inactivated Polio Vaccine (IPV) Series		
Measles, Mumps, Rubella (MMR) Vaccine Series		
Varicella Vaccine Series		

These shaded boxes indicate when the vaccine is recommended for all children unless your doctor tells you that your child cannot safely receive the vaccine.

These shaded boxes indicate the vaccine should be given if a child is catching-up on missed vaccines.

These shaded boxes indicate the vaccine is recommended for children with certain health conditions that put them at high risk for serious diseases. Note that healthy children **can** get the HepA series[6]. See vaccine-specific recommendations at www.cdc.gov/vaccines/pubs/ACIP-list.htm.

FOOTNOTES

[1] Tdap vaccine is combination vaccine that is recommended at age 11 or 12 to protect against tetanus, diphtheria and pertussis. If your child has not received any or all of the DTaP vaccine series, or if you don't know if your child has received these shots, your child needs a single dose of Tdap when they are 7 -10 years old. Talk to your child's health care provider to find out if they need additional catch-up vaccines.

[2] All 11 or 12 year olds – both girls *and* boys – should receive 3 doses of HPV vaccine to protect against HPV-related disease. Either HPV vaccine (Cervarix® or Gardasil®) can be given to girls and young women; only one HPV vaccine (Gardasil®) can be given to boys and young men.

[3] Meningococcal conjugate vaccine (MCV) is recommended at age 11 or 12. A booster shot is recommended at age 16. Teens who received MCV for the first time at age 13 through 15 years will need a one-time booster dose between the ages of 16 and 18 years. If your teenager missed getting the vaccine altogether, ask their health care provider about getting it now, especially if your teenager is about to move into a college dorm or military barracks.

[4] Everyone 6 months of age and older—including preteens and teens—should get a flu vaccine every year. Children under the age of 9 years may require more than one dose. Talk to your child's health care provider to find out if they need more than one dose.

[5] A single dose of Pneumococcal Conjugate Vaccine (PCV13) is recommended for children who are 6 - 18 years old with certain medical conditions that place them at high risk. Talk to your healthcare provider about pneumococcal vaccine and what factors may place your child at high risk for pneumococcal disease.

[6] Hepatitis A vaccination is recommended for older children with certain medical conditions that place them at high risk. HepA vaccine is licensed, safe, and effective for all children of all ages. Even if your child is not at high risk, you may decide you want your child protected against HepA. Talk to your healthcare provider about HepA vaccine and what factors may place your child at high risk for HepA.

For more information, call toll free **1-800-CDC-INFO** (1-800-232-4636) or visit **http://www.cdc.gov/vaccines/teens**

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

Please use this grid below to help you schedule immunizations for children.

Co-payments (AHCCCS Co-payments)

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

THE FOLLOWING PERSONS ARE NEVER ASKED TO PAY CO-PAYMENTS:

- 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
- People who are eligible for Medicare Savings Programs only*
- 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 who receive hospice care

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

IN ADDITION, CO-PAYMENTS ARE NEVER 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
- Services paid on a fee-for-service basis

NOMINAL (LOW) CO-PAYS FOR SOME AHCCCS PROGRAMS

Most people who get AHCCCS benefits are asked to pay the following nominal co-payments for medical services:	
Prescriptions	$2.30
Outpatient 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.

PEOPLE WITH REQUIRED CO-PAYMENTS

Families with Children that are no Longer Eligible Due to Earnings

If a family is no longer eligible for any AHCCCS program due to higher income that they get from working, the family can still get AHCCCS benefits through the Transitional Medical Assistance (TMA) program. People on TMA have to pay higher co-pays for some medical services and will need to pay the co-pays in order to get the services.

A family receiving TMA will not be required to make the co-pays if the total amount of the co-pays the family has made is more than 5% of the family's gross family income (before taxes and deductions) during a calendar quarter (January through March, April through June, July through September, and October through December.)

When a family receiving TMA benefits thinks that they

Families receiving TMA benefits have the following co-payment amounts:	
Prescriptions	$2.30
Doctor or other provider outpatient office visits for evaluation and management of your care	$4.00
Outpatient physical, occupational and speech therapies	$3.00
Outpatient non-emergency or voluntary surgical procedures	$3.00

Pharmacists and medical providers can refuse services if the co-payments are not made.

have paid copays that equal 5% of the family's total quarterly income and AHCCCS has not already told them this has happened, they should send copies of receipts or other proof of how much they have paid to AHCCCS, 801 E. Jefferson, Mail Drop 4600, Phoenix, Arizona 85034.

If you are on this program but your circumstances have changed, contact your local DES office to ask them to review your eligibility.

OTHER ADULTS - (Childless Adults) An adult may get AHCCCS benefits through the AHCCCS Care Program. An adult is on AHCCCS Care because the adult:

- Does not have an eligible deprived child living with them (see Arizona Administrative Code R9-22-1427),
- Is not pregnant,
- Is not aged 65 or over, or
- Is not disabled.

People on AHCCCS Care have to pay higher co-pays for some medical services and will need to pay the co-pays in order to get the services.

IMPORTANT: The copays for people in the AHCCCS Care Program may change because of a lawsuit. If there are changes to these co-pays in the future, AHCCCS will tell you.

Persons on AHCCCS Care will need to make the following co-payments in order to receive the following services:	
Generic Prescriptions and Brand Name Prescriptions when there is no generic	$4.00
Brand Name Prescriptions when there is a generic prescription that can be used	$10.00
Non-emergency use of an emergency room	$30.00
Doctor or other provider outpatient office visits for evaluation and management of your care	$5.00
Taxi ride to obtain medical services (for adults in Maricopa and Pima Counties only)	$2.00 each way

Pharmacists, Medical Providers and taxi companies can refuse services if the co-payments are not made.

If your circumstances have changed and you don't think you belong in the AHCCCS Care program, contact your local DES office to ask them to review your eligibility.

Non-covered Services

- 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 (except insulin and insulin syringes).
- Private or special duty nurses.
- 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.
- 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.
- **Transplants including:**
  - Pancreas only transplants (total, partial or islet cell)
  - Any other transplant not listed by AHCCCS as covered
- Physical exam for non-medical purposes (for example, job, school or insurance exams).
- Well Exams for members ages 21 and older (visits to the doctor when you are not sick).
- Chiropractic services except for EPSDT* services.

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

- 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).

THE MOST RECENT BENEFIT EXCLUSIONS AND LIMITATIONS ARE DESCRIBED IN THE FOLLOWING TABLE.

The following services are not covered for adults 21 years and older. 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 EXCLUSIONS OR LIMITATIONS
Insulin Pumps	A machine that is worn to give insulin through the day to a person as needed.	AHCCCS will not pay for insulin pumps. Supplies, equipment maintenance (care of the pump) and repair of pump parts will be paid for.
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 Bone-Anchored Hearing AID (BAHA). Supplies, equipment maintenance (care if 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.	AHCCCS will no longer pay for orthotics. Supplies, equipment maintenance and repair of component parts will be paid for. Orthotics means items like leg braces, wrist splints and neck braces. Maintenance (care of existing orthotics) and repair of parts will still be paid for.
Inpatient Hospital Stays	A stay in an Acute Care hospital including Specialty Care Hospitals and Rehabilitation Hospitals.	AHCCCS will no longer pay for inpatient hospital stays for adults aged 21 years or older past the 25th day for Acute, ALTCS and DDD members. The limit applies for stays within a 12 month period of time running from October 1 to September 30 of the following year.

CONTINUED...

BENEFIT/ SERVICE	SERVICE DESCRIPTION	SERVICE EXCLUSIONS OR LIMITATIONS
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.
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.
Well Exams	Well exams are when a person visits the doctor for a check up when they are not sick.	Well visits are not paid for. Well visits are when a person goes to the doctor's office for a routine checkup instead of going for a cold or some other sickness or problem. *However, pap smears, mammograms, and colonoscopies will still continue to be covered.*
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 are limited to 15 visits per contract year (10/01- 09/30). The member who has Medicare should talk to the health plan for help in determining how the visits will be counted.

You may be billed 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 the Customer Care Center if you would like more information about this.

PAYING FOR NON-COVERED SERVICES

If you ask about a service or prescription that is not a covered benefit, the provider will tell you what it will cost. You can decide if you want to pay for the service or medicine yourself. If you choose to do this, you will have to sign a written statement agreeing to pay for the costs yourself.

MHP WILL ONLY PAY FOR CARE APPROVED BY MHP, UNLESS IT IS AN EMERGENCY SERVICE

- You must see your PCP first. You can then be referred by your PCP to see another doctor. Some services may require additional approval by MHP before care can be given.
- Women do not need a referral to go to a network obstetrics/gynecology specialist for preventive and routine services.
- MHP will not pay for care or medicines unless they are ordered by your PCP or by a doctor you were referred to by your PCP and they are in the Plan's approved list. Medicines not on the MHP-approved list will not be paid for unless a doctor or PCP obtains prior authorization and after it has been shown that the drugs on the approved list will not work for you.
- MHP members do not need a referral for Behavioral Health services.

SERVICES NOT APPROVED BY MHP – NOTICE OF ACTION

If MHP does not approve care or medicine ordered by your PCP, you will receive a written notice of action. 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 MHP reduces stops or ends 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 may file an appeal either verbally or in writing. It must be done through MHP within sixty (60) days from the date of the notice of action. MHP will provide you with a written decision within thirty (30) days of filing the appeal.

An expedited request is when a medically necessary item or procedure is needed within three (3) business days. Your PCP has asked for this request on your behalf and has determined that waiting longer than three (3) business days may jeopardize your well being. An expedited request must be approved, denied, or pended for additional information if needed, within three (3) business days from the date MHP receives the request. If not approved, MHP must inform you and your PCP in three (3) business days.

MHP can request an extension for up to fourteen (14) days to allow time for the PCP to send additional information. If additional information is not received, the request will be denied.

If an expedited request is received and does not meet the criteria for expedited request, the request will be worked as standard request and the member and provider will be notified. If you are not satisfied with the decision by MHP you have the right to complain to AHCCCS, Division of Health Care Management, Medical Management Unit.

BILLING FOR A COVERED SERVICE

You should not be billed or receive a bill for services covered under the plan. Please call MHP Customer Care to help fix any billing problems.

Other Benefits

Referrals to Specialists

MEDICAL SERVICES:

Some medical services and specialists need prior approval by MHP. If they do, your PCP will arrange for a prior authorization for these services. MHP must review these requests. Your PCP's office will let you know if your prior authorization request is approved. You can also call Customer Care to find out the status.

If your PCP's request is denied, MHP will let you know by mail. If you have a question about the denial, you may call Customer Care or write to us at the address listed on the front of this handbook. Please see page 28 for more information about filing an appeal for a denied authorization. The letter sent by MHP will also tell you how to request a hearing directly with AHCCCS.

NOTE: Women can have a Pap or mammogram screening once a year without a referral from their PCP. For members 21 years and older, well visits* are no longer covered. Please see the excluded benefits table on page 22. Please contact Customer Care for more

information on Pap smears, mammograms, and colonoscopies.

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

Behavioral Health Services

If you feel that you need help with an emotional, alcohol or drug problem, you do not need a referral. For non-emergency help, you may call the following people:

- Your PCP
- Customer Care
- MHP Behavioral Health Case Manager of the Day during business hours
- Your Regional Behavioral Health Authority (RBHA)

Please refer to page 11 for a more complete description of services available.

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 Customer Care 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. MHP is responsible for making any co-payment, coinsurance or deductibles, even if the services are provided outside of the MHP Network.

If a third party insurer (other than Medicare) requires the member to pay any co-payment, coinsurance or deductible, MHP is 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. MHP is not responsible for paying coinsurance and deductibles that are more than MHP 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, MHP 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.) MHP will not cover co-pays 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 Customer Care and let us know about the different coverage that you have? Because it will help you get the maximum benefits from all insurance plans!

NOTE: If you are on a Medicare HMO and have MHP, you MUST choose a PCP that is contracted with both plans in order for medical services to be covered.

IMPORTANT INFORMATION FOR AHCCCS MEMBERS WITH MEDICARE PART D COVERAGE:

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

Transportation: Rides to Medical Appointments

EMERGENCY

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.

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

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. There is a "Family & Friends" transportation program available. If you prefer to have a family member or friend transport you to an appointment, please call us for more information. Your family member or friend may be paid for this service.

BUS TICKETS

You can contact Customer Care to see if you qualify for bus tickets to go to medically necessary visits.

Providers must be in our network to use bus tickets.

TAXI RIDES

If you cannot use the bus service for health reasons, you may be able to get a taxi ride. Call Customer Care at least three to four days before your scheduled visit.

On weekends and holidays, you can call Customer Care for taxi rides to urgent care centers when you are sick. Always remember to dial 911 in a true medical emergency.

AHCCCS CARE MEMBERS MAY NOW HAVE A $2.00 CO-PAY FOR TAXI SERVICES. PLEASE REFER TO PAGE 21 FOR SPECIFIC DETAILS.

CAR SEAT, WHEELCHAIR OR STRETCHER

If you need a car seat, wheelchair or a stretcher for your ride to a routine doctor's visit, please be sure to specify that when arranging a ride.

You must call Customer Care to set up these rides at least three to four 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. 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 Customer Care to cancel your ride to your visit.

Emergency Room & Urgent Care Use & Tips

An Urgent Care is a great place to get medical help because they usually have extended hours, specialists for common problems, and can see you quickly (usually 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. The Urgent Care can be used for problems your doctor would normally help with. If your doctor wouldn't be able to take care of the problem, the Urgent Care probably can't either. Emergency rooms are good choices if you have broken bones, cannot stop bleeding, or you are experiencing chest pains or shortness of breath.

HOW DO YOU 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 to make an appointment. If your doctor is unable to see you, or the office is not open, Urgent Care is an excellent option. If you need help finding an Urgent Care in our network, call Customer Care.

If you're not sure whether to go to Urgent Care or the Emergency Room, just ask yourself these questions:

Is this something my PCP can take care of in his/her office?

- **If yes-** call your PCP to schedule an appointment or visit an Urgent Care if your PCP office is not open.
- **If no-** go to the Emergency Room.

Is this something that, <u>if untreated soon</u>, my life could be in danger or I could lose a body part?

- **If yes-** go to the Emergency Room.
- **If no-** call your PCP to schedule an appointment or visit an Urgent Care if your PCP office is not open.

If I do need to go to the Emergency Room, should I call 911 to get medical help right away?

- If your life is in immediate danger, please call 911.
- If your problem is not life threatening, and can be handled by your PCP or Urgent Care, please go there instead.

WHAT IF YOU NEED EMERGENCY CARE OUT OF OUR SERVICE AREA?

MHP will only pay for emergency care while you are out of the county or state. If you need emergency care, show your AHCCCS 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 Maricopa Health Plan you have the right to seek Emergency Service at any hospital or other Emergency Room facility (in or out of network).

The Emergency Room is not the place to treat earaches, colds or the flu. For these conditions, contact your PCP's office first. If you cannot make an appointment with your PCP, call Customer Care to find an Urgent Care center in our network.

Please remember it is always very important to tell the Emergency Department staff that you are a Maricopa Health Plan member and show your AHCCCS Identification Card. If you are unable to do this, have a family member or friend tell the Emergency Department staff that you are a Maricopa Health Plan member.

TIPS ON WHEN THE EMERGENCY ROOM SHOULD NOT BE USED:

Do not go to the Emergency Room for symptoms your primary care doctor or Urgent Care can treat. **The Emergency Room is for emergencies only!**

If the condition is not life threatening, contact your PCP office any time. Your PCP's office will decide the level of care you need. In addition, if you need care after office hours, on weekends or holidays call the Customer Care Center to find an Urgent Care close to you.

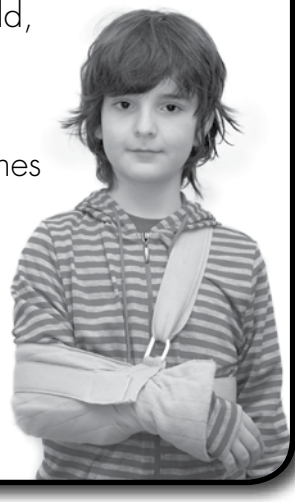
Should you go to the Emergency Room or Urgent Care?

Examples of **Emergency Room Symptoms**

- Extreme shortness of breath
- Fainting
- Poisoning
- Chest pains
- Uncontrolled bleeding
- Seizures

Examples of **Urgent Care Symptoms**

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



Member Rights

Concerns or Grievances about Maricopa Health Plan

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

Maricopa Health Plan
Attn: Grievance & Appeals Department
2701 E. Elvira Road
Tucson, AZ 85756

Phone: 1-800-582-8686,
ask for Grievance & Appeals

Fax: (520) 874-3462 or
1-866-465-8340

WHAT IF YOU HAVE QUESTIONS, PROBLEMS OR COMPLAINTS ABOUT MHP?

Call Customer Care if you have a specific grievance or dissatisfaction with any aspect of your care. Examples of grievances are: service issues, transportation issues, quality of care issues and provider office issues. Interpretation services are available in any language at no cost to you. You may call Customer Care to file a grievance (complaint). You may also file your grievance in writing by mailing it to the address listed above. Your grievance will be reviewed and a response will be provided no later than ninety (90) days from the date that you contact us. You can also file a complaint regarding the adequacy of the Notice of Action letter, a denial of service by MHP. If we cannot take care of your concern with the adequacy of the Notice of Action letter or have not effectively resolved the issue, you can also call AHCCCS: Division of Health Care Management – Medical Management Unit.

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 MHP 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 review of an "Action".

The phrase "Notice of Action letter" is a written notice from MHP regarding an "Action" MHP has taken.

WHAT IF YOU DISAGREE WITH A DENIED SERVICE?

If you disagree with an "action" or denial of health care services taken by MHP you may file an "appeal". You may file your appeal in writing or by phone. An appeal must be filed in writing within sixty (60) days from the date of your denial, suspension, reduction or termination Notice of Action letter. You may call and ask to speak to an Appeals representative to file an appeal or you can mail or fax the Grievance &Appeals Department at:

Maricopa Health Plan
Attn: Grievance & Appeals Department
2701 E. Elvira Road
Tucson, AZ 85756

Phone: 1-800-582-8686, ask for Grievance & Appeals

Fax: (520) 874-3462 or
1-866-465-8340

WHO MAY FILE AN APPEAL?

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

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 the contractor's network under 42CFR 438.52 (b)(2)(ii), when the contractor is the only contractor in the rural area.

WHAT ARE THE TIMEFRAMES FOR MHP TO MAKE DECISIONS ABOUT SERVICES?

MHP has 14 days to review and decide if the requested services are not approved. For an expedited or fast request, MHP has three (3) 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 services happens, we will notify you at least ten (10) days before the change.

WHAT MHP WILL DO WHEN YOUR APPEAL IS RECEIVED?

We will send you a letter with in 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. MHP 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 or your provider can 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.

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 the 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 an extension is give, your appeal will be decided in forty four (44) days rather than thirty (30) days. 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 MHP. This request must be made in writing to MHP within thirty (30) days of the date of receipt of the appeal decision. You can mail or fax your request. MHP will send your appeal file to AHCCCS 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 or your provider can 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 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 MHP within ten (10) days of the receipt of the notice of action letter. However, you may be responsible for payment of those services if MHP upholds the denial.

Member Rights and Responsibilities

OUR COMMITMENT TO YOU

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.

MEMBER RIGHTS

1. You will receive care that meets your needs in a way that doesn't judge race, gender, religious beliefs, values, language, how much a person is able to do, age, handicap, or ability to pay.
2. You will be treated with respect and dignity. We understand your need for privacy and confidentiality including protection of any information that identifies you.

3. You will be treated in a safe, supportive and smoke-free environment.
4. You have the right to information about MHP's services, health care providers, admission, transfer, discharge, billing policies, and members' rights and responsibilities.
5. You have the right to choose your primary care physician within the MHP network.
6. The law states that you have the right to read or get copies of your medical records at no cost to you. However, your right to access medical records may be denied if the information is psychotherapy notes, compiled for, or in a reasonable anticipation of a civil, criminal or administrative action, protected health information subject to the Federal Clinical Laboratory Improvement Amendments of 1988 or exempt pursuant to 42 CFR 493.3(a)(2).
   - You have the right to have MHP amend or correct your medical records.
   - You have the right to review your medical records if you are denied access to inspect or obtain a copy.

MHP 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, MHP 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.

7. You have the right to help in decision making about your health care and Advance Directives (decisions about what kind of care you would like to receive if you become unable to make medical decisions).
8. You have the right to complain to us about MHP and/or care provided.
9. You have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
10. Your wishes are important. You have the right to the information needed to help you make informed decisions. Here is a list of some, but not all of your rights:
    - You can accept or refuse any treatment. You will be informed of any consequences of refusing treatment.
    - You can receive information on available treatment options and alternatives presented in a manner appropriate to the enrollee's condition and ability to understand the information.
    - You can make Advance Directives and appoint someone to make health care decisions for you. You or your representative can change your Advance Directives at any time.
    - You or someone who represents you can take part in resolving problems about your health care decisions.
11. You have the right to the following:
    - You can be told about Physician Incentive Plans that affect referral services.
    - You have the right to know that MHP is required to participate in a stop-loss insurance program.
    - You can be told the types of plans MHP uses for compensation.
    - You can get a summary of member survey results.
12. You have the right to have language interpretive services from a provider who speaks your primary language, if other than English.
13. You have the right to have a list of available PCPs, including those who speak a language other than English.
14. You have the right to a second opinion from a qualified health care professional within MHP's network. If an in-network second opinion is not available, you have the right to have a second opinion arranged outside of the MHP network at no cost to you.
15. You have the right to request a copy of the Notice of Privacy Practices at no cost to you. The notice describes MHP's privacy practices and how we use health information about you and when we may share that health information with others.
16. You have the right to request the criteria that decisions are based on.

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.

MEMBER RESPONSIBILITIES

1. It is your responsibility to provide, to the best of your knowledge, information to help the MHP staff care for you.
2. It is your responsibility to follow instructions and guidelines given by those providing health care.

3. It is your responsibility to know the name of your assigned PCP.
4. It is your and your family members' responsibility to be considerate of the rights and property of patients and staff. This includes smoking and visitation policies.
5. It is your responsibility to pay your co-payments for care received as soon as possible.
6. It is your responsibility to schedule appointments during medical office hours whenever possible before using urgent care.
7. It is your responsibility to arrive on time and to let the medical office know in advance when you can't keep an appointment.
8. It is your responsibility to bring immunization records to every appointment for children ages 20 and younger.
9. It is your responsibility to watch over children with you at all times.
10. It is your responsibility to cancel your ride when you cancel your appointment.
11. It is your responsibility to NOT behave in a way that disrupts and/or does not allow a doctor to serve you or another patient in a safe way.
12. It is your responsibility to provide information requested to verify your account. This includes your name, birth date, ID number, phone number, and address.

Advanced Directives

The law requires doctor and health care facilities to inform you, in writing, of your right to create "Advance Directives" relating to your medical care. Advanced 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 Advanced Directives are the Living Will and the Durable Power of Attorney.

Even though you have made Advanced Directives, 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 Directives. Ask your PCP to make the Advance Directive a part of your medical record.

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 MHP provider.
- 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:
Unnecessary costs to the program because of:

- Providing false materials or documents.
- Leaving out important information.

ABUSE BY A PROVIDER: 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 a Maricopa Health Plan provider or member of fraud and abuse, please contact us at any of the following:

MHP Customer Care Phone: 1-800-582-8686

MHP Compliance Department Phone: (520) 874-5075

MHP Compliance Department Fax: (520) 874-7072

MHP Compliance Department E-mail: *Compliance@uahealth.com*

MHP Compliance Department Mail:

Maricopa Health Plan
Compliance & Audit Department
2701 E. Elvira Rd.,
Tucson, AZ 85756

Compliance Hotline (outside agency open 24 hours) at 1-800-910-6716

Or Report it to AHCCCS at:

Member Fraud: (602) 417-4193 or 1-888-487-6686

Provider Fraud: (602) 417-4045 or 1-888-487-6686

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 Maricopa Health Plan. We look forward to serving you!

Notes:

Notes: