Member Handbook

October 1, 2022 to September 30, 2023

Care1st Health Plan Arizona
1850 West Rio Salado Parkway • Suite 211 •
Tempe, Arizona 85281

Member Services: **1-866-560-4042** • TTY/TDD **711**
care1staz.com

CARE1ST HEALTH PLAN ARIZONA

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MEMBER HANDBOOK

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1850 West Rio Salado Parkway • Suite 211 • Tempe, Arizona 85281

Member Services:

Toll Free: **1-866-560-4042** (TTY/TDD **711**)

Website:

care1staz.com

A copy of this member handbook is available at no charge by calling Member Services. You can also find it at **care1staz.com**.

Revised October 1, 2022

Covered services are funded under contract with AHCCCS.

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Welcome to Care1st

Thank you for choosing Care1st Health Plan Arizona (Care1st). We are happy to serve you and your family and to give you the quality healthcare services you deserve. This Member Handbook helps you learn how to work with Care1st. Please read this handbook. It will help you get the most out of your healthcare plan.

We regularly add new providers to our network. Visit findaprovider.care1staz.com to see the most current Provider Directory. The Provider Directory has information on our network providers, including:

- Name
- Address
- Telephone numbers
- Whether they are accepting new patients
- Professional qualifications
- Language(s) spoken
- Gender
- Specialty
- Board certification status

To get a copy of the directory or a new Member Handbook, please call Member Services. You can reach us at the phone number listed at the bottom of this page. You can get both of them at no charge.

In the welcome packet you got when you were enrolled, a letter listed the Primary Care Provider (PCP) we chose for you. If you would like to choose a different PCP, please call Member Services at the number listed below or write to us at the address on the front cover page.

This Member Handbook is only a summary of Care1st services. Please call Member Services if you have questions about anything in this handbook.

Care1st Department Contact Information

Member Services

Member Services, also called Customer Service, helps you with questions or concerns you may have. Member Services can help you choose or change your PCP and find other providers. They can help find a pharmacy near you or help you make an appointment.

Member Services staff is here for you Monday through Friday from 8 a.m. until 5 p.m. The telephone number for Member Services is **1-866-560-4042** (TTY/TDD **711**). You can

find this number on the bottom of each page of this handbook. You can use this number to call Member Services, who can transfer you to any department that provides services directly to members, such as Medical Management and Pharmacy. If you have an urgent problem and cannot wait for normal business hours, call Member Services. Our off-hours service will help you.

Care Management

Care1st understands you may have special care needs. To help with those needs, Care1st created a **Care Management Program**. The goal of this program is to help you understand how to take care of yourself.

You may qualify for Care Management services if you:

- Need help with getting care and/or using medical or behavioral services
- Have a serious or long-term medical or behavioral health condition. This can be something like asthma, diabetes, Human Immunodeficiency Virus (HIV) / Acquired Immunodeficiency Syndrome (AIDS), depression, substance abuse, or a high-risk pregnancy

While in the program, you work with a Care Manager who will:

- Ask questions to get more information about your condition or need
- Identify your support system (family, guardian, and/or caregiver) and how much you want them involved in your care
- Teach you and your support system about your health condition and medications
- Speak with you and your support system about your benefits and needed service
- Work with your PCP, specialist, or behavioral health provider to get you the services you need
- Give you information to help you and your support system understand how to care for yourself and how to get services, including local resources

To learn more about this no-cost program, or for other Care Management or Medical / Behavioral Management help, call **1-866-560-4042** (TTY/TDD **711**).

Maternal Child Health

If you are pregnant, a **Maternal Child Health (MCH) Coordinator** can help you with questions or problems with your pregnancy. If you need help finding a provider to take care of you during your pregnancy and delivery, call **1-866-560-4042** (TTY/TDD **711**) and ask to speak with a MCH.

Nurse Advice Line

If you call Care1st, you can talk to a nurse who can give you advice if you are not feeling well. Our nurses are on hand to help you 24 hours a day, seven days a week, 365 days a year. The nurse can tell you if you should:

- Call your PCP
- Go to an urgent care center, or
- Go to the emergency room

The nurse can also tell you how to take care of yourself at home when you don't feel well and if you don't think you need to see your PCP.

To get in touch with a nurse, call **1-866-560-4042** (TTY/TDD **711**). Then choose the prompt for the **Nurse Advice Line**. You can also call the Nurse Advice Line directly.

AHCCCS Complete Care (ACC) Members (Acute, General Mental Health and/or Substance Use, Children)		**Regional Behavioral Health Authority (RBHA) Members** (Members with a Serious Mental Illness - SMI Designation)
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1-800-746-3163	**1-877-236-0375**	**1-877-236-0375**

In an emergency go to the nearest hospital or call **911** right away.

Quality Improvement Program

Care1st has a comprehensive Quality Improvement Program to ensure that you get quality care and services. We are always happy to share information with you. For more information about the Quality Improvement Program or if you would like a copy of the program, please call Member Services at **1-866-560-4042** (TTY/TDD **711**) or visit the Care1st website at **care1staz.com**.

Urgent Care

Urgent care is needed when you have an injury or illness that must be treated within 24 to 72 hours. It is not life-threatening. However, you cannot wait for a PCP office visit. Urgent care is not emergency care.

If you have a sudden health problem that is not an emergency, call your PCP. Your PCP can let you know what to do. When the office is closed, your call may go to an answering service. Listen carefully. You may be asked to leave a message so that the PCP can call you back.

If you are unable to reach your PCP, you can be seen at an urgent care center. You do not need an appointment to be seen at an urgent care center. You must use an urgent care center that is part of the Care1st network. For a list of urgent care centers near you, visit **care1staz.com**.

Behavioral Health Crisis Services

People reach out to a crisis hotline for all sorts of behavioral health problems, including:

- Depression
- Anxiety
- Suicidal thoughts
- Bipolar disorder
- Post-traumatic stress disorder (PTSD), and
- Eating disorders

If you are having a behavioral health problem, a mental health crisis, and/or suicidal thoughts, you are not alone. Many people have similar struggles. There are resources to get help. During a crisis, you might feel like things will never change. Calling a behavioral health crisis line is a good way to begin getting help.

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

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

How to Get Emergency Services While Out of the Service Area

You may need emergency services while you are away from home or out of the Care1st service area. This is called "**out-of-area care.**" You have a right to use any hospital or other setting for emergency care. If you need out-of-area emergency care:

- Go to a hospital or crisis center and ask for help.
- Ask the hospital or crisis center to call **1-866-560-4042** (TTY/TDD **711**).
- For life-threatening emergencies, always call **911**.

If you have an emergency, you can get emergency services at any hospital or other emergency room facility (in or out of network). Emergency services do not require prior authorization.

You can choose any hospital or other setting for emergency care. However, there are certain emergency settings such as urgent care, Nurse Advice Line, or Telehealth services within the Care1st network that may be easier for you to use.

Crisis lines are available 24 hours a day, seven days a week, 365 days a year. They are live answered by trained staff. Crisis services also include 24/7 mobile crisis response, 23-hour crisis observation and stabilization services (including detox), and more. Crisis services are available to all individuals regardless of their AHCCCS availability. If transportation is needed to a crisis center, Care1st can help. **But if you are afraid that you or someone you know might hurt themselves or someone else, call 911 right away.**

Behavioral Health Crisis Line Information

- *State-wide 24-Hour Crisis Line:*
  - **1-844-534-HOPE** (**4673**) (TTY/TDD **711**)
- *Especially for Teens:*
  - Teen Life Line (call or text) – **602-248-TEEN** (**8336**)
- *Especially for Veterans:*
  - Veterans Crisis Line – **1-800-273-8255** (press 1) or text to **838255**
  - Be Connected – **1-866-4AZ-VETS** (**429-8387**)

Local Crisis Receiving Centers

- Northern Arizona
  - *The Guidance Center:* 2187 N Vickey St, Flagstaff, AZ 86004, **928-527-1899**
  - *West Yavapai Guidance Center:* 3343 N Windsong Dr, Prescott Valley, AZ 86314, **928-445-5211**
  - *Changepoint Integrated Care:* 2500 E Show Low Lake Rd, Show Low, AZ 85901, **928-537-2951**
  - *Mohave Mental Health Clinic:* 3505 Western Ave, Suite A, Kingman, AZ 86409, **928-757-8111**
  - *Southwest Behavioral Health:* 1633 S Plaza Way, Flagstaff, AZ 86001, **1-877-756-4090**

The Warm Line is a no-cost, private phone service. It is staffed by people who have dealt with behavioral health challenges in the past. You can get support, even if you just need someone to talk to. The Warm Line is available 24 hours a day, seven days a week, 365 days a year.

- *Northern Arizona Warm Line:* **1-888-404-5530**

Accessing Substance Use Treatment

Care1st members can have substance use treatment services at no cost. Our Care1st Member Services team is here to help you get services and/or answer questions about substance use or opioid treatment. You can access these services in a variety of ways:

- Call Member Services at **1-866-560-4042**
- Talk to your Primary Care Provider (PCP)
- Visit **findaprovider.care1staz.com** for a list of contracted behavioral health providers
- Visit the AHCCCS Opioid Service Locator at **opioidservicelocator.azahcccs.gov**.

Funding is available through state and federal grants for treating Opioid Use Disorder for uninsured and underinsured citizens of Arizona. More information about these programs is available on our website or by calling Member Services at **1-866-560-4042** (TTY/TDD **711**).

Care1st has grants to help with substance use disorder and opioid use. These grants can give some treatment and support for a short time. These grants include the State Substance Use Disorder Services (SUDS) program, State Opioid Response (SOR), the State Opioid Response II (SOR II).

Some examples of services funded by these state grants are:

- Opioid Use Disorder grants for uninsured and underinsured people
- Outreach and prevention activities
- Helping people with going back into the community after leaving jail or prison
- Training (schools, health plans and other places)

Learn more about opioid use disorder and/or treatment at **https://www.azahcccs.gov/Members/BehavioralHealthServices/OpioidUseDisorderAndTreatment**

Ensuring Culturally Competent Care (In Your Language)

We value you, and we understand that our members come from many diverse cultural and ethnic backgrounds. We know your health may be affected by your beliefs, culture, and values. We also want you to be able to fully understand the information given to you. Auxiliary aids are services or devices that help people who need extra support to communicate. These services are at no cost to you.

We offer translation in more than 140 languages, including American Sign Language, and can give you interpreter services for your healthcare visits. Our Provider Directory at **care1staz.com** has the languages spoken by each provider in our network. We regularly add new providers to our network. Visit **care1staz.com** for the most current Provider Directory. To get a printed copy of the Provider Directory or a new Member Handbook, call Member Services at the phone number listed at the bottom of this page. You can get both of them at no charge. Member materials can also be found at **care1staz.com**.

You can get member materials, along with this handbook, translated for you at no cost in your language or in a format that may be easier for you to use, such as:

- Large print
- Braille
- Audio compact disc (CD)
- With taglines in the prevalent, non-English languages in Arizona

To get information in another language or format, if you need an interpreter, or if you need help with auxiliary aids, or reading level of materials, please call Member Services. There is no cost to you for any of these services. You can find network providers who accommodate members with physical disabilities, accessible equipment, and culturally competent communications by calling Member Services at **1-866-560-4042** (TTY/TDD **711**) or visiting **care1staz.com**. Care1st follows all applicable federal and state laws.

If you would like to choose a provider based on convenience, location, disability accommodations, or cultural preference, please call Member Services at **1-866-560-4042** (TTY/TDD **711**). You may also call Member Services if you would like help making, changing, or canceling appointments with your provider(s).

What to Know Before You Visit a Provider Not in The Care1st Network

Care1st is a managed care plan. This means that you need to use doctors and other providers that are part of the Care1st network. Unless prior approval was received from Care1st, services must be received from a healthcare provider who is contracted with Care1st. Non-contracted providers must get approval from Care1st before providing services. Make sure the provider knows that you are a Care1st member. If you cannot find a provider contracted with Care1st that can meet your treatment needs, please call Member Services at **1-866-560-4042** (TTY/TDD **711**) for help. Visit **care1staz.com** to find our Provider Directory. You may also call Member Services to request a printed copy. We will send you one at no charge.

Where We Serve and How to Use Our Services

Care1st is an AHCCCS health plan. AHCCCS, or Arizona Health Care Cost Containment System (Arizona's Medicaid agency), and the State of Arizona awarded Care1st a contract in **Apache, Coconino, Mohave, Navajo and Yavapai counties** to serve you and to help you get the quality healthcare services that you deserve. Care1st is a managed care plan. This means that you need to use a Primary Care Provider (PCP) and other providers that are part of the Care1st network.

Your PCP acts as the "gatekeeper" for your healthcare. This means that your PCP helps you to arrange most of your healthcare needs. Your PCP helps you get care if you:

- Need to see a specialist
- Have a special test or treatment, or
- Go to the hospital

Sometimes your PCP needs to ask Care1st to approve your treatments or visits to another provider before you get services. Unless prior approval was received from Care1st, services must be received from a healthcare provider in our network. Make sure the provider knows that you are a Care1st member. Always remember to bring your member ID card with you to your appointment(s).

Your Identification (ID) Card

Care1st will mail your ID card to you. It identifies you as our member. It is important that you carry this card with you. Show it whenever you get care. If you do not get your ID card in the mail, call Care1st Member Services at the number listed at the bottom of this page.

Your Care1st ID card lets people know you are eligible for our services. Show your Care1st ID card when you:

- Have a doctor's appointment
- Pick up a prescription, or
- Go to the hospital
- Get any other medical and behavioral healthcare

It is very important that you keep your ID card when you get it. Do not throw away your card. Carry your ID card with you at all times.

If you have any other insurance, please be sure to show that card too whenever you get services.

If you have an Arizona driver's license or State ID card, AHCCCS will get your photo from the Motor Vehicle Division (MVD). When providers pull up the AHCCCS eligibility verification screen, they will see your picture (if available) with your coverage details.

You must protect your ID card. You may not lend, sell, or give your ID card to another person. Letting someone else use your ID card is fraud. If you do loan or give the card to someone else, you could lose your AHCCCS eligibility. You could also have legal action taken against you.

Call Care1st Member Services at **1-866-560-4042** (TTY/TDD **711**) if your ID card is lost or stolen.

Member Responsibilities

As a Care1st member, you have certain responsibilities.

You have the responsibility to:

1. Respect your providers, their staff, and the other people who provide services to you.
2. Carry your ID card with you at all times and identify yourself as a Care1st member before you get any services.

3. Understand your health problems and participate in making mutually-agreed-upon treatment goals, to the degree possible. Tell your PCP or other Care1st providers if you do not understand your condition or your treatment plan.
4. Give your PCP or other Care1st providers complete information about your health and all ongoing care you get. Tell them about past problems or illnesses you have had, if you have ever been in the hospital, and all drugs and medicines that you are taking. Tell them whenever you see other providers, when you are prescribed medicines, or if you have to go to a hospital or emergency room.
5. Tell your PCP or other Care1st providers about any changes in your health or medical condition.
6. Tell Care1st Member Services, your PCP, and other Care1st providers about any other insurance you have.
7. Keep your AHCCCS eligibility up to date. Keep all of your AHCCCS eligibility appointments and tell your eligibility worker when anything that could affect your eligibility changes in your household.
8. Keep your ID card safe. Do not throw it away. You may not loan, sell, or give your ID card to another person. Letting someone else use your ID card is fraud. If you do loan or give the card to someone else, you could lose your AHCCCS eligibility. You could also have legal action taken against you.
9. Tell Care1st or AHCCCS if you suspect fraud or abuse by a provider or another member.
10. Know the name of your PCP. Keep your PCP's name, address, and telephone number where you can easily find it.
11. Take an active part in managing your healthcare and take care of problems before they become serious. Ask questions about your care.
12. Follow your provider's instructions carefully and completely. Make sure that you understand these instructions before you leave your provider's office.
13. Take all your medications and take part in programs that help to keep you well.
14. Make appointments with your PCP during office hours instead of using urgent care or the emergency room for things that are not urgent or emergencies.
15. Keep all of your scheduled appointments and be on time. Call the provider's office ahead of time if you need to cancel an appointment or if you are going to be late.
16. Bring your children's shot records to all of their PCP visits.
17. Pay your copay when needed (see additional information in the Copayment section of this handbook).

18. Call or write Member Services when you have questions, problems, or grievances (complaints).
19. Schedule your transportation at least three days in advance. Notify transportation if you need to change or cancel your appointment.

Please call or write to Member Services with questions or comments about this.

Changes in Family Size or If You Move

Tell your eligibility worker if your family gets bigger because of a birth or marriage. Make an appointment with your eligibility worker to add your new family member to AHCCCS. You must also report changes if your family gets smaller. This may happen because a family member moves away or because of a death in your family.

Also, if you move out of Apache, Coconino, Mohave, Navajo, and Yavapai counties, out of Arizona or out of the United States, you must contact your eligibility worker. AHCCCS only covers emergency services outside of those counties. Routine care is not covered outside those counties. No services are covered outside of the United States. It is important to get in touch with your eligibility worker so you may get full services in your new area.

If you move within Apache, Coconino, Mohave, Navajo, and Yavapai counties, it is still important to call the eligibility worker. You may miss important notices and information if AHCCCS and Care1st do not have the right address for you.

If you need to report a change in your household including, but not limited to, a change of residential or mailing address, your income, household member's change of job, etc., contact the eligibility source where you applied for AHCCCS:

- DES: **www.healthearizonaplus.gov** or **1-855-HEA-PLUS** (**1-855-432-7587**)
- KidsCare: **www.healthearizonaplus.gov** or **1-855-HEA-PLUS** (**1-855-432-7587**)
- SSI MAO: **www.healthearizonaplus.gov** or **602-417-5010** / **1-800-528-0142** Outside Maricopa County
- Social Security Administration: **1-800-772-1213**
- Arizona Long Term Care System (ALTCS) Local Offices: **1-888-621-6880** or fax: **1-888-507-3313**
  Mailing address: 801 E Jefferson St, MD 3900, Phoenix, AZ 85034

Visit **www.azahcccs.gov/AHCCCS/Downloads/HowToUpdateYourMailingAddress.pdf** for more information.

Annual Enrollment Period – AHCCCS Complete Care (ACC) Only

Title XIX/XXI members enrolled with Care1st for both physical and behavioral health services are known as ACC members. If you are an ACC member, you will be given a chance to choose another health plan once a year on the date that you enrolled with AHCCCS (your anniversary date). AHCCCS will send you a letter two months before your anniversary date to tell you how you may change health plans.

Please call Care1st before you change plans. We would like to know about any problems you have with Care1st so that we can look for a solution. We value you as a member and would like you to remain with Care1st.

Health Plan Changes

If you want to change your health plan before or after your anniversary date, you must call AHCCCS at 1-800-654-8713. The following are the only reasons that AHCCCS will give you an immediate (outside of your anniversary) change of health plans:

1. You were not given a choice of health plans.
2. You were not told of your Annual Enrollment Choice, or you got your Annual Enrollment Choice notice but could not make a choice because of things beyond your control.
3. You did not get to make an Annual Enrollment Choice because you were not on AHCCCS during your Annual Enrollment Choice period, but the time you were not on AHCCCS was less than 90 days.
4. You have other members of your family who are enrolled in another health plan.
5. You came back on AHCCCS within 90 days of leaving it and were not given the same health plan as before.
6. You did not have 90 days from the date of notification of plan assignment to choose a new health plan for your newborn.
7. You did not have 90 days from the date of enrollment to choose a new health plan for your adoption subsidy child.
8. You are Title XIX eligible and did not have 90 days from the date of your eligibility interview, or from the date that you got your choice letter, to choose a new health plan.

Other plan change requests must be made to your current health plan. If you want to change to another health plan, please call Member Services. If you are on another health plan and want to change to Care1st, contact your current health plan. Your health plan may only consider plan change requests for one of the following reasons:

- You are pregnant and were already getting prenatal care when you were enrolled in the health plan.
- You need to continue treatment with a medical provider that you were seeing when you were enrolled in the health plan. Your provider will need to prove to both the health plan that you want to leave and the health plan that you want to join that a plan change is necessary.

If there are other members in your family who are also AHCCCS-eligible and enrolled with your current health plan, you may include them in your plan change request. Our policy is to take steps to make sure your change is smooth.

Family Voice & Decision Making

Our healthcare providers are expected to include any family members / support system that you identify along with any other authorized healthcare decision-maker(s) in the treatment planning process. It is important that your family / support system and other authorized individuals attend as many discussions as possible regarding treatment planning for you and/or your child. That way, you will be able to make the most informed decisions. If you feel your voice is not being heard, please call Member Services at **1-866-560-4042** (TTY/TDD **711**) and ask to speak to our Individual and Family Affairs (OIFA) team for help.

Transition of Care

We will make sure you keep getting any active treatment(s) you are currently getting when you either join or leave Care1st. If you are leaving Care1st to go to another health plan, AHCCCS Fee-For-Service (FFS), or AHCCCS American Indian Health Program (AIHP), we will send all important information to your new health plan within 10 calendar days of your change. If you are new to Care1st from another health plan, AHCCCS FFS, or AHCCCS AIHP, our transition coordinator will review your care needs.

Emergency Care

AHCCCS covers medically necessary emergency care 24 hours a day, seven days a week, 365 days a year. An emergency is an illness, injury, symptom, or condition (including severe pain) that a reasonable person could expect that not getting medical attention right away would:

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

If you have an emergency, go to the nearest hospital or call **911** right away. In an emergency you may go to or use any emergency room (in or out of network) to get your emergency care. When you get care, show your ID card and tell them that you are a Care1st member. You do not need a referral from your provider or prior authorization from the plan.

Call your PCP or the Care1st 24-hour Nurse Advice Line if you are not sure if it is an emergency.

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If you have a problem that needs to be seen urgently but is not life-threatening, you may be able to be seen at an urgent care center or at your PCP's office. Some examples of the difference between an emergency and something you might need to be seen urgently are listed below.

Examples of non-emergency conditions that can be seen by your PCP or an urgent care center:

- Colds, sore throats, earaches, coughs,rashes
- Minor cuts, abrasions, or non-life-threatening bug stings
- Headaches, including migraines
- Simple urinary tract infection, fever, vomiting, diarrhea
- Prescription drug refills or orders
- Removal of stitches
- Backaches or other muscle aches
- Employment exams or urine tests
- Joint aches or sprains
- Lumps or bumps that are new

Examples of emergency conditions that are life-threatening or can cause major problems if not taken care of right away:

- Trouble breathing
- Deep cuts or bleeding that you cannot stop
- Loss of consciousness
- Severe chest pain
- Drug overdose or poisoning
- Serious burns or electric shock
- Pain and/or bleeding if you are pregnant
- Broken bones
- Head injury
- Eye injury
- Persistent high fever
- Severe persistent headache
- Stroke symptoms: slurred speech, sudden numbness or loss of strength, confusion
- Heart attack symptoms: chest pain, trouble breathing, left arm pain
- Asthma attacks: severe breathing difficulties
- Snake bites with swelling, trouble breathing, or lightheadedness

After you get home from the emergency room, call your PCP for an appointment. When you call to make an appointment with your PCP, tell them that you have been at the emergency room. Be sure to tell your PCP about any instructions or medicine that you were given at the emergency room.

Emergency Transportation

If you think you need an ambulance, call **911** right away. If you are not sure, call your PCP and follow their advice. Or call the Care1st Nurse Advice Line.

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Do Not Use the Emergency Room or an Ambulance for Routine or Urgent Healthcare Services.

Non-Emergency Transportation

Non-Emergency Transportation (Taxi Rides)

Care1st provides medically necessary taxi rides to and from the nearest appropriate provider for members who do not have another way to get to medical appointments. Before you call Care1st for transportation, you should:

- Try to use your own car
- Use public transportation
- Arrange a ride with a family member or friend

Transportation is provided to the member who has the appointment and a parent if the member is a minor under the age of 21. To arrange for a taxi ride to an appointment, call us at least three business days ahead of the appointment. Please call Monday through Friday between 8 a.m. and 5 p.m., except for holidays. We may not be able to arrange transportation unless you call three business days in advance. Members must have their own car seat for children under 8 years of age.

Urgent Transportation – If you need to go to an urgent care center or see your PCP right away because of an urgent condition, please call us to arrange transportation. These types of requests do not need a three-business day advance notice.

Hospitalization

If you need to go to the hospital and it is not an emergency, your provider arranges the stay. Care1st and your provider must approve your hospital visit before you go.

Covered Services

Below is a list of some of the services that are covered by AHCCCS. This is not a complete list. All services must be medically necessary. If you have any questions about covered services, you may call Member Services, your PCP, or contact your behavioral health provider. For some services, you may need a referral from your PCP or behavioral health provider before you have the service. Care1st may need to review and approve this referral. If Care1st does not approve your referral, they will send you a notice letting you know. Be sure to check with your PCP or behavioral health provider before getting services. Care1st does not restrict services based on moral or religious objections. If you are trying to access services, including counseling or referral services, and your provider is unable or unwilling to help due to moral or religious objections, please call Member Services.

Adults with (SMI) who are enrolled in Medicaid

If you are an adult enrolled in Medicaid and Care1st, and you have been designated as Seriously Mentally Ill, you can get both your physical health and behavioral health care through Care1st.

Adults with SMI who are not enrolled in Medicaid

If you are enrolled with Care1st as a Non-Medicaid Adult designated with Serious Mental Illness (SMI), you are eligible for a limited behavioral health benefit only.

Some individuals are eligible for both AHCCCS and Medicare. These individuals are called "Dual Eligible." If you are enrolled in Medicare, Care1st may help pay your Medicare coinsurance and deductibles for Medicare Parts A and B covered services. This is called "Cost Sharing." Care1st may also help with other costs if you use Care1st providers, and your provider follows all of the Care1st rules for cost sharing.

1. AHCCCS-approved organ and tissue transplants and related drugs
2. Behavioral health services (for more information see Behavioral Health Services page 57)
   - Behavior Management (behavioral health personal care, family support/home care training, self-help/peer support)

- Behavioral Health Case Management Services
- Behavioral Health Nursing Services
- Emergency Behavioral Healthcare
- Emergency and Non-Emergency Transportation
- Evaluation and Assessment
- Individual, Group and Family Therapy and Counseling
- Inpatient Hospital Services
- Non-Hospital Inpatient Psychiatric Facilities Services (Level I residential treatment centers and sub-acute facilities)
- Laboratory and Radiology Services for Psychotropic Medication Regulation and Diagnosis
- Opioid Agonist Treatment
- Partial Care (Supervised day program, therapeutic day program and medical day program)
- Psychosocial Rehabilitation (Skills training and development and psychosocial rehabilitation living skills training, including supported employment services)
- Psychotropic Medication
- Psychotropic Medication Adjustment and Monitoring
- Respite Care – temporary residential care for patients that provides relief for the permanent caregivers (with limitations)
- Rural Substance Abuse Transitional Agency Services
- Screening
- Behavioral Health Therapeutic Home Care Services

3. Chiropractic care visits (for members under age 21 and Qualified Medicare Beneficiary or "QMB" members)
4. Emergency care
5. Emergency transportation
6. Family Planning Services and Supplies including birth control and contraceptives
7. Hearing evaluations and treatment (hearing aids) for members under age 21
8. Hearing evaluations for members age 21 and over

9. Home and community-based services (if used instead of a nursing facility)
10. Home health services (if used instead of hospitalization)
11. Hospice
12. Incontinence briefs for members ages 3–20 (who meet certain requirements)
13. Inpatient and outpatient hospital care (see Non-Covered Services page 29)
14. Insulin pumps
15. Kidney dialysis
16. Limited dental services for members age 21 and over (see Adult Services page 50)
17. Maternity care for pregnant members
18. Medically necessary foot care by a licensed Podiatrist and ordered by a PCP
19. Medically necessary transportation
20. Most medically necessary supplies and equipment
21. Nutritional evaluations
22. Orthotic devices for members under the age of 21 are provided when prescribed by the member's PCP, attending physician, or practitioner. Medical equipment may be rented or purchased only if other sources, which provide the items at no cost, are not available. The total cost of the rental must not exceed the purchase price of the item. Reasonable repairs or adjustments of purchased equipment are covered for all members over and under the age of 21 to make the equipment serviceable and/or when the repair cost is less than renting or purchasing another unit. The component will be replaced if at the time authorization is sought documentation is provided to establish that the component is not operating effectively.
23. Orthotic devices for members 21 years of age and older when all of the following apply:
    - The use of the orthotic is medically necessary as the preferred treatment option consistent with Medicare Guidelines, and
    - The orthotic is less expensive than all other treatment options or surgical procedures to treat the same diagnosed condition, and
    - The orthotic is ordered by a Physician or Primary Care Practitioner
24. Pharmacy/medications (on Care1st's list of covered medications)
25. Preventive dental care and dental treatments for members under age 21

26. Preventive services including, but not limited to, screening services such as cervical cancer screening including pap smears, mammograms, colorectal cancer, and screening for sexually transmitted infections

27. Rehabilitation services – outpatient speech, occupational and physical therapy (see Non-Covered Services)

28. Skilled Nursing home care (if used instead of hospitalization) up to 90 days a year

29. Vision care including eyeglasses for members under age 21

30. Vision care for members age 21 and over following cataract surgery, and for emergency eye conditions

31. Visits with a nurse practitioner or physician's assistant

32. Well child care (EPSDT care) including immunizations

33. Well visits (well exams) such as, but not limited to, well woman exams, breast exams, and prostate exams are covered for members. Most well visits (also called checkup or physical) include a medical history, physical exam, health screenings, health counseling and medically necessary immunizations. Early Periodic Screening, Diagnostic, and Treatment (EPSDT) visits for members under 21 years of age are considered the same as a well visit.

34. Female members, or members assigned female at birth, have direct access to preventive and well care services from a gynecologist or other maternity care provider within Care1st's network without a referral from a primary care provider

35. X-rays, lab work and other tests

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

If you have any questions about what services are covered, please call Member Services or talk to your PCP.

Additional Medical Covered Services For Medicaid-Enrolled Youth Under the Age of 21

These services are also available to members that are under 21 years of age and are enrolled in Medicaid:

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

Community Connections Is Here for You

Everyone deserves to live their best life possible. Yet a lot of things can affect your ability to do that. A phone call to our Community Connections Help Line can put you in touch with services to help you. Plus, it's here for Care1st members, non-members, and caregivers. Our Peer Coaches listen to your needs and refer you to resources all over the country or right in your local area. Call to get the help you need: **1-866-775-2192**

Get connected with the right social services, including:

- Financial help (i.e., utilities, rent)
- Affordable childcare
- Medication help
- Job/education help
- Transportation
- Family supplies – diapers, formula, cribs and more
- Food help
- Support groups

Non-Covered Services and Service Exclusions/Limited Benefits

The following services are not covered for adults 21 years and older (if you are a Qualified Medicare Beneficiary, we will continue to pay your Medicare deductible and coinsurance for these services):

AHCCCS Excluded/Limited Benefits Table		
Benefit/Service	**Service Description**	**Service Excluded/Limited From Payment**
Bone-Anchored Hearing Aid	A hearing aid that is put on a person's bone near the ear by surgery. This is to carry sound.	AHCCCS does not pay for Bone-Anchored Hearing AID (BAHA). Supplies, equipment maintenance (care if the hearing aid) and repair of any parts are paid for.
Cochlear Implant	A small device that is put in a person's ear by surgery to help you hear better.	AHCCCS does not pay for cochlear implants. Supplies, equipment maintenance (care of the implant) and repair of any parts are 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 does not pay for a lower limb (leg, knee or foot) prosthetic that includes a microprocessor (computer chip) that controls the joint.
Dental Services	Any care or treatment of the teeth.	See Adult Services for a detailed explanation of limited dental services for members over age 21.
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 behavioral health services is 600 hours within a 12-month period of time. The 12 months run from Oct. 1 to Sept. 30 of the next year.

AHCCCS Excluded/Limited Benefits Table		
Benefit/Service	**Service Description**	**Service Excluded/Limited From Payment**
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 (PT)	Exercises taught or provided by a physical therapist to make you stronger or help improve movement.	Inpatient care: PT services are covered for all members who are getting inpatient care at a hospital, nursing facility, or custodial care facility. Outpatient care: PT services are covered for members under the age of 21. The following limitations apply to members 21 years of age and older: • 15 PT visits per benefit year* for the purpose of restoring a skill or level of function and maintaining that skill or level of function once restored. • 15 PT visits per benefit year* for the purpose of acquiring a new skill or a new level of function and maintaining that level of function once acquired. A member who has Medicare should talk to Care1st for help in determining how the visits will be counted.

AHCCCS Excluded/Limited Benefits Table		
Benefit/Service	**Service Description**	**Service Excluded/Limited From Payment**
Occupational Therapy (OT)	Exercises taught or provided by an occupational therapist to help you gain, restore, or keep a skill or function.	Inpatient care: OT is covered for all members who are getting inpatient care at a hospital, nursing facility, and custodial care facility when services are ordered by the member's PCP or attending physician. Inpatient OT consists of evaluation and therapy. Outpatient care: OT services are covered for ALTCS members and for members under the age of 21. The following limitations apply to members 21 years of age and older: • 15 OT visits per benefit year* for the purpose of restoring a skill or level of function and maintaining that skill or level of function once restored. • 15 OT visits per benefit year* for the purpose of acquiring a new skill or a new level of function and maintaining that skill or level of function once acquired. A member who has Medicare should talk to Care1st for help in determining how the visits will be counted.

AHCCCS Excluded/Limited Benefits Table		
Benefit/Service	**Service Description**	**Service Excluded/Limited From Payment**
Speech Therapy (ST)	Diagnostic and treatment services that include evaluation, program recommendations for treatment, and/or training in receptive and expressive language, voice, articulation, fluency, rehabilitation, and medical issues dealing with swallowing.	Inpatient care: ST services are covered for all members who are getting inpatient care at a hospital, nursing facility, or custodial care facility. Outpatient care: ST services are covered for members under the age of 21. A member who has Medicare should talk to Care1st for help in determining how the visits will be counted.

*Benefit year is from October 1 through September 30.

For All Members

Below are more services that are not covered by AHCCCS. This is not a complete list. If you have any questions about covered services, call Member Services or talk to your PCP.

1. Abortions or abortion counseling (except when the pregnancy is the result of rape or incest, or if a physical illness related to the pregnancy endangers the health of the pregnant individual)
2. Circumcision (unless medically necessary)
3. Cosmetic services
4. Experimental services
5. Hysterectomy (surgery to remove the uterus) that is not medically necessary
6. Infertility and/or reversal of elective sterilization
7. Medicines not on Care1st's approved list of drugs (formulary) unless prior approved by Care1st
8. Personal or comfort items
9. Physical exams for school, work, or sports

10. Services or items that are given at no cost or for which charges are not usually made
11. Services or items that need to be prior approved by Care1st, where prior approval was not given
12. Gender-affirming surgery
13. Services from a provider who is NOT contracted with Care1st (unless prior approved by Care1st)

Non-Title XIX/XXI Services

If you are enrolled with Care1st and want to find out about Non-Title XIX/XXI services, the Regional Behavioral Health Authority (RBHA) in your area, Care1st, is responsible for providing these services. Non-Title XIX/XXI services may include, but are not limited to, room and board, mental health services (formerly known as traditional healing), and auricular (ear) acupuncture.

For more information on RBHA services, based on your county of residence, contact:

- For Apache, Coconino, Gila, Mohave, Navajo, and Yavapai counties: *Care1st* Member Services at **1-866-560-4042** (TTY/TDD **711**)
- For Maricopa County: *Mercy Care* Member Services at **1-800-564-5465** (TTY/TDD **711**)
- For Cochise, Graham, Greenlee, La Paz, Pima, Santa Cruz, and Yuma counties: *Arizona Complete Health-Complete Care Plan* at **1-888-788-4408** (TTY/TDD **711**)

If you need help finding a RBHA near you or help accessing services, call our Member Services.

Housing Services

Supportive Housing is a service available for Care1st members, which helps individuals get safe and stable housing to live independently in the community of their choice. Applications for housing help can be sent to the AHCCCS Housing Administrator by either a member's provider or Care1st. Housing services are offered consistent with Substance Abuse and Mental Health Services Administration (SAMHSA's) evidenced-based practice of permanent supportive housing. Regional Behavioral Health Authorities work with system partners such as the U.S. Department of Housing & Urban Development (HUD), Arizona Department of Housing, local housing authorities, and local

housing continuum of care coordinated entry for homeless services. The number of members that can be helped with housing in any given year depends on funding levels. If you would like to learn more about housing support and services, please call Care1st Member Services at **1-866-560-4042** (TTY/TDD **711**).

If you need help finding a place to live or help paying for housing, Care1st's Housing Specialist can help connect you with community and housing resources in your area.

If necessary, Care1st will refer you to the AHCCCS Housing Administrator for Non-Title XIX/XXI services and local community housing providers. Call Care1st Member Services Line at **1-866-560-4042** (TTY/TDD **711**) and ask to speak with the Housing Specialist or email **housing@care1staz.com**.

Agencies that can talk to you about resources and other housing options:

Name	Who or How They Can Help	Website or Contact Information
Arizona Department of Housing	General housing information	**https://housing.az.gov/**
Balance of State Continuum of Care (CoC)	Northern Arizona and Balance of State Coordinated Entry	**https://housing.az.gov/general-public/homeless-assistance**
Maricopa County Continuum of Care (CoC)	Maricopa County Coordinated Entry	**https://azmag.gov/Programs/Homelessness**
Pima County Continuum of Care (CoC)	Pima County Coordinated Entry	**https://tpch.net**
Housing Solutions of Northern Arizona	Transitional living, credit counseling, and affordable rentals	**https://www.housingnaz.org**
Housing Authority of Flagstaff Arizona	Help for low-income families	**http://www.flagstaff.az.gov/2342/HousingAuthority**
Mohave County Housing Authority	Housing help and Housing Choice Voucher	**https://www.publichousing.com/details/mohavecounty**

Name	Who or How They Can Help	Website or Contact Information
Catholic Charities Community Services	Help with food, clothing, and shelter in Coconino and Mohave counties	**https://www.catholiccharitiesaz.org/**
Northern Arizona Council of Governments (NACOG)	Help with emergency rental	**https://nacog.org/**
Navajo Nation in Flagstaff	General housing help	**http://www.navajo-nsn.gov/**
Western Arizona Council of Governments (WACOG)	Homeless prevention and utility help in Mohave, La Paz, and Yuma counties	**https://www.wacog.com/**
ABC Housing	Provides quality, affordable housing and supportive services for persons with behavioral health needs in Arizona	**https://azabc.org/**
Housing Operations and Management (HOM), Inc	Operates Permanent Supportive Housing and Rapid Rehousing programs for vulnerable individuals and families experiencing homelessness and housing instability	**https://www.hominc.com/**
Changepoint Integrated Health	**Navajo County** Show Low, Pinetop-Lakeside, Holbrook, and Winslow	**https://www.mychangepoint.org/**
Encompass Health Services	**Mohave County** Colorado City, Littlefield **Coconino County** Page, Fredonia	**https://www.encompass-az.org/**

Name	Who or How They Can Help	Website or Contact Information
Little Colorado Behavioral Health Centers, Inc	**Apache County** Springerville, St. Johns	**https://www.lcbhc.org/index.php**
Mohave Mental Health Clinic, Inc	**Mohave County** Bullhead City, Kingman, Lake Havasu City	**https://www.mmhc-inc.org/locations/**
Polara Health	**Yavapai County** Prescott Valley, Prescott, Chino Valley	**https://www.polarahealth.com/**
Southwest Behavioral & Health Services, Inc	**Yavapai County** Prescott Valley, **Coconino County** Flagstaff **Mohave County** Bullhead City, Kingman, Lake Havasu City	**https://www.sbhservices.org/contact-locations**
Spectrum Healthcare Group, Inc	**Yavapai County** Prescott, Cottonwood, Camp Verde	**https://www.spectrumhealthcare-group.com/**
The Guidance Center, Inc	**Coconino County** Flagstaff	**https://tgcaz.org/**

Advance Care Planning/End-of-Life Care

What is advance care planning?

Advance care planning is a service that supports conversations between patients and their providers to decide what type of care patients want if they cannot make their own medical decisions.

During these conversations, providers talk through and help the person plan for a time when they cannot make their own medical decisions. If you have a life-threatening condition, the provider may talk to you about creating a written plan that:

- Notes the treatments you choose to have
- Explores how your illness will progress over time, as well as your fears and concerns about your illness
- Shares your wishes with family members and friends, and/or
- Makes care choices in case of a critical event, like a stroke, and how aggressive you want your treatment to be (for example, resuscitation status, antibiotics, feeding tubes).

Is advance care planning the same as an advance directive?

Advance care planning is not the same as an advance directive. An advance directive is a legal document that says what should happen if a person is no longer able to make their own medical decisions. Advance directives take many forms. These may be living wills and durable powers of attorney for healthcare. An advance directive should be completed according to AZ state rules to make the documents legally binding.

Does a person have to have a terminal illness to take advantage of this benefit?

No. The advance care planning benefit is open to anyone. Often the best time to begin to discuss end-of-life care may be before a person is diagnosed with a life-threatening condition. This gives plenty of time to consider one's preferences. Having these talks early may also be useful in guiding future care and treatment decisions by family members and caregivers should the person become incapacitated and unable to make their choices known. Advance care planning is not meant to be a one-time conversation, but a series of talks over the course of a person's life.

End-of-life discussions include advance care planning with the goal to provide treatment, comfort, and quality of life.

Source: **https://www.ncoa.org/article/medicare-advance-care-planning**

Specialist Services & Referrals

Specialists are providers who take care of special health problems. Your PCP helps arrange most of your care and refers you to a specialist when needed. Care1st may need to review and approve this referral. If we do not approve your referral, we send you a notice to let you know.

If you have question about specialist services and referrals, please call Member Services at **1-866-560-4042** (TTY/TDD **711**).

If you are trying to get services, including counseling or referral services, and your provider is unable or unwilling to help due to moral or religious objections, please call Member Services.

Members with special healthcare needs may get specialist services without a referral from their PCP when said PCP has a standing referral agreement with the specialist. You may choose a specialist from Care1st's provider network.

Members Who Are American Indian

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

Member Services

Care1st Member Services will help you with any problems or questions that you may have. Member Services can help you choose or change your PCP. They can help you:

- Find a pharmacy
- Find a behavioral health provider near you, or
- Help you make an appointment

Member Services staff is available Monday through Friday from 8 a.m. until 5 p.m. to help you. The telephone number for Member Services is at the bottom of each page of this handbook. If you have an urgent problem and cannot wait for regular business hours, please call Member Services. Our off-hours service will help you.

Your Primary Care Provider (PCP)

Your PCP is your main gatekeeper. They help make sure that you get the healthcare you need. Your PCP will help to arrange most of your care. Your PCP will send you to a specialist when needed. You do not need a referral from your PCP for:

- Visits to a Care1st dentist for members under the age of 21
- Behavioral health services
- Preventive and well care services from a gynecologist within the Care1st network, or
- Cervical cancer screenings or mammograms
- Special services if you have special healthcare needs and your PCP has a standing referral agreement with the specialist

If you are pregnant, please refer to the Prenatal Care section. If you have special healthcare needs and need to see a specialist on an ongoing basis, your PCP will help you arrange this. It is important to talk to your PCP about all of your healthcare needs. Learning more about you and your health helps your PCP give you quality care.

If you are a new member of Care1st, you should make an appointment for a checkup as soon as possible. This checkup lets you and your PCP get to know each other and is good for your health.

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

If you want services, including counseling or referral services, and your provider is unable or unwilling to help due to moral or religious objections, please contact Member Services.

How to Choose a PCP

You can choose a PCP from the Care1st Provider Directory. The directory has the languages that each provider speaks. You may get information about network providers who accommodate members with disabilities. Just call Member Services at **1-866-560-4042** (TTY/TDD **711**). You can visit **care1staz.com** for the most current directory. You can also call Member Services to request a copy be sent to you at no cost.

You may choose a different PCP for each family member that is with our plan.

How to Change Your PCP

You may change your PCP at any time. To change your PCP, choose a PCP from the Care1st Provider List. You can also visit care1staz.com for the most up-to-date list. Call or write Member Services with your choice. Here are some reasons you might change your PCP:

- You do not feel comfortable talking to your PCP
- You do not understand what your PCP says
- Your PCP's office is too far away
- Your PCP will not give you the services you need because of moral or religious objections

Be sure to tell Member Services about your PCP choices if you are also changing the PCP for any or all members of your family.

How to Make an Appointment

Most of the time providers cannot see you unless you have an appointment. When you call to make an appointment with a PCP or specialist, be ready to tell the office:

- Your name (or the name of your child if the appointment is for your child)
- Your (or your child's) ID number
- That you (or your child) are a Care1st member, and
- The reason you need the appointment

Please keep all of your appointments.

To Cancel or Change an Appointment

Try to call at least one day in advance when you need to cancel or change an appointment. It is very important to keep your appointments or let the office know ahead of time if you cannot keep your appointment.

Appointment Availability Standards

You should be able to get an appointment within the following times based on the type of provider, service being received, and the urgency of the appointment:

PCP	• ***Urgent** – As expeditiously as the member's health condition requires but no later than 2 business days of request • **Routine** – Within 21 calendar days of request
Specialty/Dental Specialty	• ***Urgent** – As expeditiously as the member's health condition requires but no later than 2 business days of request • **Routine** – Within 45 calendar days of request
Dental	• ***Urgent** – As expeditiously as the member's health condition requires but no later than 3 business days of request • **Routine** – Within 45 calendar days of request

Maternity	• **First Trimester – Within 14 calendar days of request** • **Second Trimester – Within 7 calendar days of request** • **Third Trimester – Within 3 business days of request** • **High Risk Pregnancies** – As expeditiously as the member's health condition requires and no later than 3 business days of identification of high risk by Care1st or maternity care provider, or immediately if an emergency exists
Behavioral Health –Provider Appointments	• **Urgent Need** – As expeditiously as the member's health condition requires but no later than 24 hours from identification of need • **Routine Care** – Initial assessment within 7 calendar days of referral • **The first behavioral health service following the initial assessment.** Within the time frame indicated by the behavioral health condition **1.** For members age 18 years or older, no later than 23 calendar days after the initial assessment **2.** For members under the age of 18 years old, no later than 21 days after the initial assessment • **All subsequent services** – As expeditiously as the member's health condition requires, but no later than 45 calendar days from the identification of need
Behavioral Health – Psychotropic Medications	• Assess the urgency of the need immediately • If clinically indicated, provide an appointment with a Behavioral Health Medical Professional (BHMP) within the time frame that ensures the member a) does not run out of needed medications; or b) does not decline in their behavioral health condition prior to starting medication, but no later than 30 calendar days from the identification of need

Please call Member Services if you cannot get an appointment within these times.

Waiting at Your Provider's Office

Sometimes you may have to wait at the office while your provider sees other patients. You should not have to wait more than 45 minutes unless your provider has an emergency. If you were on time to your appointment, and you had to wait more than 45 minutes for a provider that was not busy because of an emergency, please call Member Services.

Well Visits

Well visits (well exams) are covered for members. Most well visits (also called checkup or physical) include a medical history, physical exam, health screenings, health counseling, and medically necessary immunizations. Early Periodic Screening, Diagnostic, and Treatment (EPSDT) visits for members under 21 years of age are considered the same as a well visit.

Well Woman Preventive Care

An annual well woman visit is a covered benefit. This visit includes screenings that help your provider find and treat possible health problems. Your provider can also tell you about ways to stay healthy and reduce your risk of developing diseases in the future.

The following preventive services are included in a well woman visit:

1. Physical exam (well exam) that assesses overall health
2. Clinical breast exam
3. Pelvic exam and Pap smear (if necessary)
4. Any vaccines (shots), screenings, and tests for your age and risk factors
5. Screening and counseling to support good health on topics such as:
   - Proper nutrition
   - Physical activity
   - Elevated body mass index (BMI)
   - Tobacco/substance use, abuse, and/or dependency
   - Depression screening
   - Personal safety and domestic violence

- Sexually transmitted infections (STIs)
- Human Immunodeficiency Virus (HIV)
- Family planning (birth control)
- Preconception counseling that includes discussion of a healthy lifestyle before and between pregnancies (e.g., reproductive history and sexual practices, healthy weight, diet and nutrition, folic acid intake, physical activity/exercise, oral healthcare, chronic disease management, emotional wellness, tobacco and substance use including caffeine, alcohol, marijuana, and other drugs, prescription drugs, and spacing between pregnancies), and
- Referral for further screening and treatment if needed

Members have direct access to preventive and well care services from a gynecologist or other maternity care provider within Care1st's network without a referral from a primary care provider.

There is no copayment or other charge for the well woman preventive care visit.

If you need help with making an appointment or getting a ride to your well woman visit, call Care1st Member Services at **1-866-560-4042** (TTY/TDD **711**).

Adult members who lose AHCCCS eligibility may contact the Arizona Department of Health Services, Bureau of Health Systems Development. Call **602-542-1219** or use the Clinic Locator at **www.azdhs.gov/prevention/health-systems-development/sliding-fee-schedule/index.php** to find a Sliding Fee Schedule clinic that provides low or no-cost services near you.

Children's Services (EPSDT)

Early Periodic Screening, Diagnostic and Treatment (EPSDT) is a comprehensive child health program of prevention and treatment, correction, and improvement (amelioration) of physical and behavioral health conditions 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.

Amount, Duration and Scope: The Medicaid Act defines EPSDT services to include screening services, vision services, replacement and repair of eyeglasses, dental services, hearing services and such other necessary health care, diagnostic services, treatment and other measures described in federal law subsection 42 U.S.C. 1396d(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the AHCCCS state plan. 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.

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

EPSDT includes, but is not limited to, coverage of: inpatient and outpatient hospital services, laboratory and x-ray services, physician services, naturopathic services, nurse practitioner services, medications, dental services, therapy services, behavioral health services, medical equipment, medical appliances and medical supplies, orthotics, 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 experimental, solely for cosmetic purposes, or that are not cost effective when compared to other interventions.

Care1st will remind you when it is time for your child to have a checkup. It is very important for children to have their checkups. Even when your child is not sick, it is important to see a PCP regularly. These visits can help the PCP find problems early and begin treating your child right away.

There is no charge for these services, and they help your child stay healthy. EPSDT, also called well-child visits, include, but are not limited to:

1. Complete unclothed physical exam
2. Health and developmental history and assessment
3. Nutritional screening and assessment

4. Oral health (dental) screening
5. Behavioral health screening
6. Developmental screening and referral
7. Shots (immunizations)
8. Speech, hearing, and eye exams
9. Tests for tuberculosis (TB), anemia, and sickle cell trait
10. Lab tests (including blood lead screening)
11. Health education and discussion about your child's health, nutrition, and behavioral health

You may also be able to get the following services. Ask your PCP or call Member Services for information about:

1. **Women Infants and Children (WIC) program** – A community nutrition education program for pregnant, breastfeeding, and postpartum women and children to age 5. WIC can provide foods that promote good health. Benefits include:
   a. Nutritious foods at no cost
   b. Nutrition education
2. **Head Start** – A community program to give your child a head start on school. If you have a child between the ages of 2 and 4 years, they may be able to have some help in getting ready for kindergarten. Head Start helps all children succeed. Services are also available to infants and toddlers in some areas.
3. **Arizona Early Intervention Program (AzEIP)** – A community program that may give services such as physical therapy and support to children with developmental delays or disabilities up to age 3. Services that are not medically necessary would not be covered by Care1st.
4. **Behavioral Health Services** – Behavioral health services are available through Care1st unless your ID card has a specific phone number listed for Behavioral Health. Please see the Behavioral Health section of this handbook for more information and contact numbers.

Make an appointment with your child's PCP for checkups at the following ages:

- Newborn
- 3–5 days
- 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 month
- 24 months
- 30 months
- Annual visits from 3 to 20 years

Make an appointment with your child's dentist for checkups at the following ages:

- **12 months (or ask your PCP):** to start early and healthy dental habits and exams
- **12 months through age 20:** twice a year for a dental exam and cleaning

Follow-up for any problems found during these checkups is also covered. Please call Member Services or the EPSDT Coordinator at **1-866-560-4042** (TTY/TDD **711**) if you have questions about EPSDT services for your child.

Transportation at no cost is available for EPSDT visits. If you need help making appointments, please call Member Services or the EPSDT Coordinator.

If you lose eligibility, call the Arizona Department of Health Services, Bureau of Health Systems Development at **602-542-1219**. Or use the Clinic Locator at **www.azdhs.gov/prevention/health-systems-development/sliding-fee-schedule/index.php** to find a Sliding Fee Schedule clinic that provides low or no-cost services near you.

Preventive and Well Care

Female members, or members assigned female at birth, have direct access to preventive and well care services from a gynecologist or other maternity care provider within the Care1st network without a referral from a primary care provider.

Prenatal Care

Getting your prenatal care early and keeping all of your appointments are very important when you are pregnant. Call your PCP right away for an appointment if you think you might be pregnant. Your PCP can give you a test to see if you are pregnant.

If you are pregnant, you can self-refer to a Maternity Care Provider. Your PCP can also help you choose one. You may choose an OB physician, physician assistant, nurse practitioner, certified nurse midwife, or licensed midwife to take care of you during your pregnancy and your delivery. If you are getting care from a certified nurse midwife, you may also choose to get some or all of your primary care from your assigned PCP.

Licensed midwives may not give any additional medical services, as primary care is not within their scope of practice.

If your test shows that you are pregnant, or if you are pregnant when you join Care1st, call Member Services and ask to speak with a Care1st Maternal Child Health (MCH) Coordinator. They can help you find an OB doctor, certified nurse midwife, or licensed midwife to take care of you during your pregnancy and delivery. All OB services must be approved by Care1st. Your Maternity Care Provider must accept Care1st and must get approval for your care after your first visit.

The MCH Coordinator helps you with questions or problems regarding your pregnancy. If you are new to Care1st or if you have recently transitioned to Care1st, and are in your third trimester, you can keep getting your pregnancy care with your current provider. If you have any problems or questions about your pregnancy, call the MCH Coordinator at **1-866-560-4042** (TTY/TDD **711**).

Your Maternity Care Provider gives you a complete checkup on your first visit. They will also do blood and urine tests to see if you have any medical problems that could affect your pregnancy. This can include tests for sexually transmitted infections (STIs). You can get prenatal testing for HIV/AIDS. Counseling and treatment are available to you if you test positive for HIV/AIDS. Getting treatment if you test positive for HIV/AIDS can benefit you and your baby because it may help to prevent your baby from becoming infected with HIV. Your provider can talk to you about treatment options.

Your postpartum care is very important and is covered following delivery. Your provider tells you when you need to be seen for this visit, which is based on guidelines from the American College of Obstetricians and Gynecologists (ACOG). You should have a postpartum visit about four to six weeks after your baby is born. Your provider may want to see you in one to two weeks if you had a Cesarean section delivery or if you have certain medical conditions, but you should be seen again by your provider within eight weeks after delivery.

Birth control also known as family planning services and supplies is available to you. Your Maternity Care Provider will give you information on Family Planning Services. These might include birth control counseling and birth spacing. Family Planning supplies include birth control pills and shots, Long-Acting Reversible Contraceptives (LARC) diaphragms and IUDs, Immediate Postpartum Long-Acting Reversible Contraceptives (IPLARC), condoms, foams, and suppositories.

Your Maternity Care Provider will also make sure things are going well for you and your baby. Call your Maternity Care Provider about any concerns you have. Be sure to keep all of your scheduled appointments.

HIV Testing

All Care1st members (including those that have and/or have not tested positive for HIV) can get information about HIV testing, counseling, and treatment. Please call Member Services if you have questions.

Family Planning

Family planning is deciding if and/or when you want to have children. Family planning services and supplies are available at no cost to members of reproductive age. You can get family planning services and supplies from your PCP or from an AHCCCS-approved Family Planning provider. You do not need a referral from your PCP to see a Care1st Family Planning provider even if the Family Planning provider is not a Care1st network provider. Care1st can help you schedule an appointment with a Family Planning provider. We can also help with transportation. There is no charge for family planning.

Your provider can help you find the type of birth control that works for you. Family planning services and supplies include:

1. Family planning (contraceptive) counseling
2. Pregnancy tests, medical exams and lab work, including ultrasound studies related to family planning
3. Treatment of complications resulting from the use of contraceptives, including emergency treatment
4. Screening and treatment for sexually transmitted infections (STIs)
5. The following methods of birth control:
   - Birth control pills
   - Birth control shots
   - Long-acting reversible contraceptives (LARC) and immediate postpartum long-acting reversible contraceptives (IPLARC) such as:
     - Birth control implants
     - Intra-uterine devices, also known as IUDs
   - Condoms
   - Diaphragms

- Foams and suppositories
- Emergency oral contraception, also known as "the morning after pill," which should be taken within 72 hours after unprotected sex
- Sterilization (tubal ligations and vasectomies) – members must be at least 21 years old to get these services
- Natural family planning education or referral to a qualified natural family planning provider

Medically Necessary Pregnancy Terminations

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

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

Adult Services

Adults (members ages 21 and older) need to see their PCPs at least once a year. There are tests, exams, and even shots that adults should have on a regular basis. Some of these services depend on your age or sex.

For members ages 21 and older, well visits are covered. Preventive screenings are also covered. Please see the excluded / limited benefits table under Non-Covered Services. Call Member Services if you have questions on covered services. Adult covered services include:

- Colonoscopies
- Mammograms
- Pap smears or other cervical cancer screening tests
- Shots (immunizations) for diphtheria tetanus, influenza (flu), pneumococcus (pneumonia), rubella, measles, hepatitis A, hepatitis B, pertussis (as currently recommended by the CDC or ACIP), zoster vaccine for members 50 and older, and human papillomavirus (HPV) for members regardless of sex
- Information regarding HIV testing, counseling, and treatment
- Treatment for illnesses and/or chronic conditions such as diabetes, asthma, high cholesterol, hypertension, cancer, sexually transmitted diseases, tuberculosis, and HIV/AIDS

Call your PCP for an appointment. Ask them about these services. You can also talk to your PCP about:

- Tobacco
- Alcohol and drug use
- Emotional or behavioral health
- Eating right
- Exercise
- Sexual behavior and family planning services
- Preventing illness or injury

If you need help finding a provider, call Member Services.

The **Medical Management Department** has nurses who can help you manage chronic illnesses. These are long-term issues such as diabetes and asthma. These nurses are available through the Care1st Case Management/Disease Management Programs. Call Member Services at **1-866-560-4042** (TTY/TDD **711**) and ask to speak to a care coordinator if you would like to find out more about these programs.

Dental services for adults ages 21 years and older are covered if related to a medical or surgical service. This includes serious pain, infection, or fracture of the jaw. Services are limited to:

- An exam of the mouth
- X-rays
- Care of the fractured mouth or jaw
- Anesthesia
- Pain medication or antibiotics

Certain pre-transplant dental services are limited to treatment of any infection, oral disease, treatment of periodontal disease, medically necessary extractions, and simple fillings or crowns. These services may be covered only after the transplant evaluation has been completed and you have been approved for the transplant. We will also cover the cost of having teeth removed before you get treated for cancer of the jaw, neck, or head.

Adult members over the age of 21 get a $1,000 Emergency Dental benefit for each 12-month period (Oct. 1-Sept. 30).

Vision Care

Routine and emergency vision care is covered for members under age 21. You do not need a referral from your PCP to get vision services. Coverage for members ages 21 and older includes emergency and some medically necessary vision services only.

Eyeglasses and other vision services are covered for Care1st members under the age of 21 years.

EPSDT members can get glasses for vision correction. This includes, but is not limited to:

- A new prescription for glasses
- New glasses if your prescription changes
- Replacement glasses if you lose or break your glasses

Members do not need to wait for their next EPSDT well child visit to replace or repair eyeglasses.

Members do not have to upgrade their glasses. If members choose an upgrade that is not covered by AHCCCS, the member is responsible for the cost. The eyeglass provider

must make sure the member agrees to be responsible for the cost of the upgrade. The member will need to sign a paper saying that they are willing to pay for the upgrade.

Need more information? Call Care1st Member Services at **1-866-560-4042** (TTY/TDD **711**) or go to **care1staz.com**.

Dental Services

DentaQuest and Envolve Dental provide dental benefits for Care1st members on behalf of Care1st. DentaQuest and Envolve Dental take care of:

- Prior authorizations
- Claims adjudication and payment
- Provider credentialing
- Provider customer service

If you have any questions, please call DentaQuest and/or Envolve Dental.

AHCCCS Complete Care (ACC) Members (Acute, General Mental Health and/or Substance Use, Children)		**Regional Behavioral Health Authority (RBHA) Members** (Members with a Serious Mental Illness - SMI Designation)
July 1, 2022 – November 30, 2022	Beginning December 1, 2022	Beginning October 1, 2022
DentaQuest	Envolve Dental	Envolve Dental
1-800-440-3408	**1-844-876-2028**	**1-844-876-2028**

AHCCCS-Covered Dental Services

Dental services are covered for all EPSDT members under the age of 21. This includes medically necessary dental services such as:

- Dental screenings
- Preventive services
- Therapeutic dental services

- Medically necessary dentures
- Pre-transplantation dental services

All EPSDT members under the age of 21 are assigned to a Dental Home.

What is a Dental Home?

A Dental Home is the dentist you go to regularly for exams and cleanings. This dentist will take care of all of your oral care.

Member Assignment

Members are assigned to a Dental Home based on their age and their residence. A member may change their assigned Dental Home by calling DentaQuest and Envolve Dental at the phone numbers listed in the table above.

Exam Schedule

Information about how often AHCCCS members should see their dentist for routine care can be found on the AHCCCS Dental Periodicity Schedule (AMPM Policy 431 Attachment A). This schedule is also on our website at **care1staz.com**.

Care1st encourages our EPSDT members to get checkups with their dentist every 6 months starting at age 1.

How to Make, Change or Cancel a Dental Appointment

Most dentists cannot see you unless you have an appointment. When you call to make an appointment, be ready to tell the office:

- Your name (or the name of your child if the appointment is for your child)
- Your (or your child's) ID number
- That you (or your child) are a Care1st member
- The reason you need the appointment

Please keep all of your appointments. But if you need to change or cancel an appointment, try to call at least one day in advance. It is very important to keep your appointments. Let the office know ahead of time if you cannot keep your appointment.

Pharmacy Services

You must use a Care1st pharmacy (drugstore) to get your medicine. A search tool on the Care1st website lets you search for a pharmacy by name or ZIP code. Visit **findaprovider.care1staz.com**.

For more help finding a drugstore near you, call Member Services.

When your provider writes a prescription for you, there are questions you should ask before you leave the office. Ask your provider:

1. If the medicine is on the list covered by Care1st (this list is called the **formulary**).
2. What the medication is used for.
3. How many times a day to take the medicine.
4. How much medicine you should take each time.
5. How long you should take the medicine.
6. How to get a refill if needed.
7. What you should expect from the medicine. (How long will it take to work? What are the side effects?)
8. What you should do if you have a bad reaction.

All prescriptions written by your provider should be on the Preferred Drug List (PDL, or formulary). To view the PDL, please go to: **care1staz.com**.

If your provider writes a prescription for something that is not on the list, ask your provider to write you a prescription for something that is on the list. If your provider feels that you have to take a drug that is not on the list, ask the provider to contact Care1st to ask for an exception or prior authorization. Your provider must explain why you have to take a drug that is not on the PDL.

If the pharmacy tells you that Care1st will not pay for the medication, call Member Services right away. Do not pay out of your own pocket for this medicine. Pharmacies will not let AHCCCS members pay cash for their prescriptions.

The PDL does include drugs that may have limits, like:

- Age limits
- Quantity limits (how much you can get)

- Step therapy – you may need to try a certain drug before another drug can be approved
- Prior Authorization (PA or plan approval)

Either you or your provider may ask us for Prior Authorization for drugs. All decisions are made within 24 hours of receipt of the request unless more information is needed. If we need more information, we will give you a final decision within seven working days from the date of request.

If your Prior Authorization request is denied, a *Notice of Adverse Benefit Determination OR Notice of Decision* (NOD) will be mailed to you and your provider. This notice has information on how you can file an appeal.

AHCCCS & Care1st cover drugs that are medically necessary, cost effective, and allowed by federal and state law. Certain drugs are not covered. These include:

- Medications prescribed for the treatment of sexual or erectile dysfunction
- Drugs classified as DESI (Drug Efficacy Study Implementation) drugs by the FDA
- Medications that are personally dispensed by physician, dentist, or other provider. (This doesn't include remote or rural areas where there is no participating pharmacy or other pharmacies are closed.)
- Outpatient drugs for members under the Federal Emergency Service Program, except dialysis-related medications for extended services individuals
- Medical marijuana
- Drugs eligible for coverage under Medicare Part D for AHCCCS member eligible for Medicare
- Experimental medications
- Drugs furnished solely for cosmetic purposes

Specialty Medications: Some drugs are "specialty medications." These drugs are for chronic health conditions and usually need special handling, storage, or administration. Your local pharmacy cannot give you these medications. Instead, you will have to use the Care1st Limited Specialty Pharmacy Network. These pharmacies are specialty certified and can help you with disease management. The Care1st Limited Specialty Pharmacy Network includes:

- AcariaHealth Pharmacy
  - Phone: **1-800-511-5144**
- CVS Caremark Specialty Pharmacy
  - Phone: **1-800-237-2767** or **1-866-387-2573**

If you need a prescription filled after normal business hours, on the weekend, or on a holiday as a result of an emergency or following a hospital discharge, you may ask your pharmacist to call the Care1st Pharmacy Benefit Manager at **1-877-817-0474** to get a four-day supply for you. If you are having any problems getting your prescription during normal business hours, or you are at a pharmacy during normal business hours and Care1st is not paying for your medication, please call Member Services at the number on the bottom of this page. We will help you. If you are at a pharmacy after normal business hours, on the weekends, or on a holiday and you are having problems getting your prescription, or Care1st is not paying for your medication, call the Member Services phone number on the back of your ID card and press the option to speak to a nurse.

If you have other insurance, be sure to give the pharmacy your other insurance ID card and your Care1st ID card. Your other insurance must pay its share of the cost before Care1st does.

Controlled Medications: All new and refill prescriptions for (within last 60 days) short-acting opioid drugs are subject to a state restriction of a five-day initial fill limit. All long-acting opioid drugs are subject to Prior Authorization. Please note that the AZ Opioid Act has exceptions based on age and/or diseases.

Exclusive Pharmacies / Providers: An exclusive pharmacy or provider is a pharmacy or provider that you have to go to for all of your controlled medication needs. You will not be able to get controlled medication from another pharmacy or provider. Care1st will also not pay for controlled medications that are given by someone other than your exclusive pharmacy or provider.

You may have to go to an exclusive pharmacy and/or provider if:

- You use four or more pharmacies in one month
- You use four or more providers in one month
- You use four or more controlled medications and/or abuse potential drugs in one month

You may also have to go to an exclusive pharmacy and/or provider if:

- You have 12 or more controlled medications and/or abuse potential drugs in the last three months, **OR**
- You have presented a forged or altered prescription to your pharmacy, **OR**
- AHCCCS requests an exclusive pharmacy and/or provider

A member may be assigned to an exclusive pharmacy and/or provider for 12 months. Care1st will send a letter 30 days before you are enrolled in the program. This letter will give the reason that you have to use an exclusive pharmacy and/or provider.

After 12 months, we will review the exclusive pharmacy and/or provider to which you have been assigned. Care1st will notify you if the restriction will continue for another 12 months or if it will stop. If the exclusive pharmacy and/or provider is continued and you disagree with the decision, you may submit a written request for a State Fair hearing.

The exclusive provider and/or pharmacy program does not apply if:

- You are currently getting treatment for cancer
- You are in hospice care
- You live in a skilled nursing facility

For AHCCCS recipients with Medicare, AHCCCS does NOT pay for any drugs paid by Medicare Part D or for the cost-sharing (coinsurance, deductibles, and copayments) for these drugs. AHCCCS and its health plans cannot pay for medications or the cost-sharing (coinsurance, deductibles, and copayments) for drugs available through Medicare Part D even if you choose not to enroll in a Medicare Part D plan. This is because federal law requires Medicare Part D to pay for these drugs.

To find out about copayments for drugs that are covered by AHCCCS, please read the section about copayments.

Behavioral Health Services

As a Care1st member, you can get behavioral health, alcohol, and substance use services at no cost. These services can help you with problems like depression, anxiety, attention deficit hyperactivity disorder (ADHD), or substance use disorder. For members with Medicare as primary insurance, Care1st, as your secondary insurance, pays for behavioral health copayments, Medicare deductibles, and some services not covered by Medicare. Our Care1st Member Services team is here to help you get services and/or if you have questions about behavioral health services or providers. Our provider network offers culturally sensitive, individualized, and comprehensive service options for individuals, children, and families with general mental health and substance use issues. You can get behavioral health services in many ways:

- Calling Member Services at **1-866-560-4042** (TTY/TDD **711**)

- Talking to your PCP
- Visiting **findaprovider.care1staz.com** for a list of contracted behavioral health providers

You are also able to get services from a peer- or family-run organization. Peer- or family-run organizations are service providers owned, operated, and administrated by persons with lived experiences of mental health and/or substance use disorders. These organizations are based in the community and provide support services.

Here are some of the things you can find at a peer- or family-run organization:

- 1-on-1 peer support
- Daily support groups
- Social outings
- Meals
- Employment programs
- Learning opportunities
- Health and exercise programs
- Creative arts
- Resources
- Advocacy
- Volunteer opportunities
- Youth and young-adult programs
- Meeting new people
- Personal development
- Empowerment
- Extended hours and/or weekends

You can get these services by contacting a peer- or family-run organization in your area to learn what services they offer or request the service be added to your service plan at the peer- or family-run organization of your choice. Once you request service, you should get services within 30 days. If you have trouble getting timely services at the peer- or family-run organization of your choice, please call Care1st Member Services.

As a plan member, you may also be able to get a Serious Mental Illness (SMI) designation if needed. To get SMI services, the following must be met:

- You must be age 17.5 years old at the time of the assessment. For transition-age youth, an eligibility assessment is considered as part of the transition to the adult system of care.
- You must have a qualifying SMI diagnosis (i.e., bipolar, psychotic, mood, anxiety, etc.).
- You must have difficulty with functioning due to your mental illness (i.e., unable to live independently, risk of serious harm to self or others, dysfunction in daily role performance).

This is for people who need extra support. A person can request to be evaluated for SMI services any time. If you would like more information on the referral process for getting an SMI Designation you can do so by:

- Calling Member Services at **1-866-560-4042** (TTY/TDD **711**)
- Talking to your PCP
- Contacting your established behavioral health provider

Your established provider or a contracted Care1st provider completes an evaluation and a SMI assessment packet. A legal guardian / healthcare decision-maker may request an SMI evaluation be completed for the member. That assessment must be completed within seven business days of the request.

The packet is then sent to Solari. Solari reviews all requests for SMI determinations. Solari decides if the person is eligible for SMI services. Solari will make a written decision in three to 20 days. The decision will include information on how to appeal if you do not agree with the outcome. Solari uses State guidelines and criteria.

If you are not established with a behavioral health provider, Care1st Member Services can help you find a provider who can complete an evaluation or answer questions about the process. If you get an SMI designation, you will start getting your integrated behavioral and physical health services from the Regional Behavioral Health Authority (RBHA).

If you are hospitalized and need an SMI evaluation, hospital rapid response teams are available 24 hours a day, seven days a week, 365 days a year. The rapid response team will make sure that your need for an SMI evaluation and/or other behavioral health needs are met, including:

- Outpatient counseling
- Transfer to an inpatient facility
- Filing a court-ordered petition

In most cases, members who have an SMI Designation get behavioral health services from the RBHA. If you need more support, resources, or treatment information, you can get other services (housing, human rights advocate, case management) by calling your behavioral health representative at your SMI clinic.

There is also our behavioral health crisis hotline. The Statewide Crisis Line is **1-844-534-4672 (1-844-534-HOPE)**. People use a behavioral health crisis hotline for many kinds of behavioral health problems, including:

- Depression
- Anxiety
- Bipolar disorder
- Post-traumatic stress disorder (PTSD)
- Eating disorders

If you are having a mental health crisis, you are not alone. Many people have similar struggles. There are resources that can help. During a crisis, you might feel like things will never change. Calling a behavioral health crisis line is a good way to start getting support. **But if you are afraid that you or someone you know might hurt themselves or someone else, call 911 right away.**

Your PCP may be able to help with medication services if you have depression, anxiety, or ADHD. If you would like help deciding what services you need, please talk to your provider.

AHCCCS covers drugs that are medically necessary, cost effective, and allowed by federal and state law. (For an explanation and list of drugs not paid by AHCCCS for recipients with Medicare, please refer to the Pharmacy Services section.)

For information about copayments for drugs that are covered by AHCCCS, please refer to the AHCCCS Copayments section.

Arizona's Vision for the Delivery of Behavioral Health Services

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

- Easy to access to care,
- Behavioral health recipient and family member involvement,
- Collaboration with the greater community,
- Effective innovation,
- Expectation for improvement, and
- Cultural competency

The 12 Principles for the Delivery of Services to Children

1. **Collaboration with the child and family:**
   - **a.** Respect for and active collaboration with the child and parents is the cornerstone to achieving positive behavioral health outcomes, and
   - **b.** Parents and children are treated as partners in the assessment process, and the planning, delivery, and evaluation of behavioral health services, and their preferences are taken seriously.
2. **Functional outcomes:**
   - **a.** Behavioral health services are designed and implemented to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults, and
   - **b.** Implementation of the behavioral health services plan stabilizes the child's condition and minimizes safety risks.
3. **Collaboration with others:**
   - **a.** When children have multi-agency, multi-system involvement, a joint assessment is developed and a jointly established behavioral health services plan is collaboratively implemented,
   - **b.** Client-centered teams plan and deliver services,
   - **c.** Each child's team includes the child and parents and any foster parents, any individual important in the child's life who is invited to participate by the child or parents. The team also includes all other persons needed to develop an effective plan, including, as appropriate, the child's teacher, the child's Division of Child Safety (DCS) and/or Division of Developmental Disabilities (DDD) caseworker, and the child's probation officer, and
   - **d.** The team:
     - **i.** Develops a common assessment of the child's and family's strengths and needs,
     - **ii.** Develops an individualized service plan,
     - **iii.** Monitors implementation of the plan; and
     - **iv.** Makes adjustments in the plan if it is not succeeding.
4. **Accessible services:**
   - **a.** Children have access to a comprehensive array of behavioral health services, sufficient to ensure that they receive the treatment they need,

b. Case management is provided as needed,

c. Behavioral health service plans identify transportation the parents and child need to access behavioral health services, and how transportation assistance will be provided, and

d. Behavioral health services are adapted or created when they are needed but not available.

5. **Best practices:**

a. Behavioral health services are provided by competent individuals who are trained and supervised,

b. Behavioral health services are delivered in accordance with guidelines that incorporate evidence- based "best practices,"

c. Behavioral health service plans identify and appropriately address behavioral symptoms that are related to: learning disorders, substance use problems, specialized behavioral health needs of children who are developmentally disabled, history of trauma (e.g. abuse or neglect) or traumatic events (e.g. death of a family member or natural disaster), maladaptive sexual behavior, abusive conduct and risky behaviors. Service plans shall also address the need for stability and promotion of permanency in class members' lives, especially class members in foster care, and

d. Behavioral health services are continuously evaluated and modified if ineffective in achieving desired outcomes.

6. **Most appropriate setting:**

a. Children are provided behavioral health services in their home and community to the extent possible, and

b. Behavioral health services are provided in the most integrated setting appropriate to the child's needs. When provided in a residential setting, the setting is the most integrated and most home- like setting that is appropriate to the child's needs.

7. **Timeliness:**

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

8. **Services tailored to the child and family:**

a. The unique strengths and needs of children and their families dictate the type, mix, and intensity of behavioral health services provided, and

b. Parents and children are encouraged and assisted to articulate their own strengths and needs, the goals they are seeking, and what services they think are required to meet these goals.

9. Stability:

a. Behavioral health service plans strive to minimize multiple placements,

b. Service plans identify whether a class member is at risk of experiencing a placement disruption and, if so, identify the steps to be taken to minimize or eliminate the risk,

c. Behavioral health service plans anticipate crises that might develop and include specific strategies and services that will be employed if a crisis develops,

d. In responding to crises, the behavioral health system uses all appropriate behavioral health services to help the child remain at home, minimize placement disruptions, and avoid the inappropriate use of the police and the criminal justice system, and

e. Behavioral health service plans anticipate and appropriately plan for transitions in children's lives, including transitions to new schools and new placements, and transitions to adult services.

10. Respect for the child and family's unique cultural heritage:

a. Behavioral health services are provided in a manner that respects the cultural tradition and heritage of the child and family, and

b. Services are provided in Spanish to children and parents whose primary language is Spanish.

11. Independence:

a. Behavioral health services include support and training for parents in meeting their child's behavioral health needs, and support and training for children in self-management, and

b. Behavioral health service plans identify parents' and children's need for training and support to participate as partners in the assessment process, and in the planning, delivery, and evaluation of services, and provide that such training and support, including transportation assistance, advance discussions, and help with understanding written materials, will be made available.

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

Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems

1. **Respect**
   Respect is the cornerstone. Meet the person where they are without judgment, with great patience and compassion.
2. **Persons in recovery choose services and are included in program decisions and program development efforts**
   A person in recovery has choice and a voice. Their self-determination in driving services, program decisions and program development is made possible, in part, by the ongoing dynamics of education, discussion, and evaluation, thus creating the "informed consumer" and the broadest possible palette from which choice is made. Persons in recovery should be involved at every level of the system, from administration to service delivery.
3. **Focus on individual as a whole person, while including and/or developing natural supports**
   A person in recovery is held as nothing less than a whole being: capable, competent, and respected for their opinions and choices. As such, focus is given to empowering the greatest possible autonomy and the most natural and well-rounded lifestyle. This includes access to and involvement in the natural supports and social systems customary to an individual's social community.
4. **Empower individuals taking steps towards independence and allowing risk taking without fear of failure**
   A person in recovery finds independence through exploration, experimentation, evaluation, contemplation and action. An atmosphere is maintained whereby steps toward independence are encouraged and reinforced in a setting where both security and risk are valued as ingredients promoting growth.

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

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

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

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

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

Children's Rehabilitative Services (CRS) & Multispecialty Interdisciplinary Clinics (MSICS)

What is CRS?

Children's Rehabilitative Services (CRS) is a designation given to certain AHCCCS members who have qualifying health conditions. See below for more about CRS.

What are MSICs?

Multispecialty Interdisciplinary Clinics (MSICs) are clinics are where your child can see specialists all at one location and sometimes at the same appointment.

There are currently four MSICs in Arizona. They are located in Flagstaff, Phoenix, Tucson, and Yuma. Services available at these MSIC clinics include, but are not limited to, family practice, physical and occupational therapy, speech, audiology, plastic surgery, cardiology, gastroenterology, orthopedics, and neurology.

Each MSIC is listed below.

DMG Children's Rehabilitative Services (CRS) 3141 N Third Ave Phoenix, AZ 85013 **602-914-1520** or **1-855-598-1871** **www.dmgcrs.org**	Children's Clinics Square & Compass Building 2600 N Wyatt Dr Tucson, AZ 85712 **520-324-5437** or **1-800-231-8261** **www.childrensclinics.org**
Children's Health Center - Flagstaff Med Ctr 1215 N Beaver St Flagstaff, AZ 86001 **928-773-2054** or **1-800-232-1018** **www.nahealth.com/childrens-health-center**	Yuma Regional Medical Center (CRS) 2851 S Avenue B, Bldg. 25 Yuma, AZ 85364 **928-336-2777** **www.yumaregional.org/Medical-Services/Pediatric-Care/Pediatric-Sub-Speciality-Clinic/Children-s-Rehabilitation-Services**

Most of the time providers cannot see you or your child unless you have an appointment. When you call to make an appointment with a CRS Multi-Specialty Interdisciplinary Clinic (MSIC), be ready to tell the office:

- Your child's name (or your name if the appointment is for you)
- Your child's ID number (or your ID number if the appointment is for you)
- That your child is a Care1st member (or you if you are a Care1st member)
- The reason you need the appointment

If you need to change or cancel your appointment, try to call at least one day in advance. It is very important to keep your appointments. Let the office know ahead of time if you cannot keep your appointment.

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

Who Can Get a CRS Designation?

AHCCCS members may be able to get a CRS designation when they are:

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

The medical condition must:

- Need active treatment, and
- Be found by AHCCCS Division of Member and Provider Services to meet criteria as specified in R9-22-1301-1305

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

- A completed CRS application, and
- Medical documentation that shows that the applicant has a CRS-qualifying condition that needs active treatment

Care1st provides medically necessary care for physical and behavioral health services and care for the CRS condition. CRS can offer coordination of care to help your child reach their greatest potential. CRS covers many chronic and disabling health conditions. Some eligible conditions include, but are not limited, to:

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

Should your child have a condition that meets the eligibility criteria for CRS, an application will be submitted to AHCCCS. If your child is accepted into the CRS program, they will continue to get medical and behavioral health services from Care1st.

It is important that you and your support system (family, guardian, and/or caregiver) be involved in all healthcare decisions. Care1st wants to help you with this. To do this, Care1st assigns a Care Coordinator / Care Manager who will:

- Know who you want involved in your child's care and how much you want them involved
- Teach you and your support system about your child's health conditions and medications
- Talk with you and your support system about your child's benefits and needed services
- Make sure you and the support system are included in discussions of child's health needs

Member Advocacy Council

Care1st is committed to improving the service we give to our members and families by helping them get the right care at the right place and the right time. We cannot meet this goal without your help. Care1st has a Member Advocacy Council where individuals can give us feedback on what we are doing well and areas that need to be improved. The Member Advocacy Council is open to Care1st members, the parents and guardians of members (including those caring for children with special needs), and community members who are concerned about healthcare.

Council members share ideas about improving the health plan. Ideas and concerns shared during the meeting may help other members with the same issues. The Member Advocacy Council talks about these topics and more:

- Member satisfaction
- Access to care
- Care1st policies and programs
- Community resources

Member Advocacy Council meetings are held once every three months. If you want to learn more about the Member Advocacy Council or are interested in participating, please visit **www.care1staz.com/az/members/Member_Advocacy_Council.asp** or email us at **OIFA@care1staz.com**.

Prior Authorization Requests for Services and Medications

Some services must be reviewed and approved (prior authorized) by Care1st. Some examples are MRIs, pain management, and inpatient procedures / surgery. The Care1st Prior Authorization Guidelines are at **care1staz.com**. Your provider sends a request for prior authorization to Care1st for the service being requested. Care1st, per AHCCCS standards, has up to 72 hours to process an expedited (urgent) request and up to 14 calendar days for a standard (routine) request. Care1st uses nationally recognized criteria when making prior authorization decisions. These criteria are available to you upon request.

If Care1st denies a routine service requested by your provider, Care1st sends you a notice as soon as possible, but not later than 14 calendar days after we get the authorization request from your provider. If Care1st has not reached a decision by day 14, an extension may be requested if it is in the best interest of the member. Care1st may extend the time frame to make a decision by up to 14 calendar days, not to exceed the 28th day from the service request date. The notice also gives you your rights on what you can do if you do not agree with that decision.

If Care1st denies an expedited service requested by your provider, Care1st will send you a notice within 72 hours of our decision that tells you why the request was denied. If Care1st has not reached a decision within 72 hours, an extension may be requested if it is in the best interest of the member. Care1st may extend the time frame to make a decision by up to 14 calendar days, not to exceed the 17th day from the service request date.

You will get a notice if an extension is requested. The notice also gives you your rights on what you can do if you do not agree with the decision.

If Care1st reduces, suspends, or terminates a service, Care1st will send you a Notice of Adverse Determination letter at least 10 calendar days before your services are reduced, suspended, or terminated. The exceptions to this are in cases of fraud, if you have moved out of state, or you have requested the service be stopped. You have the right to file a complaint with Care1st regarding the adequacy of the Notice of Adverse Determination letter.

Prior authorization decision making is based only on appropriateness of care and service and existence of coverage. Care1st does not specifically reward practitioners or other individuals for issuing denials of coverage. Financial incentives for Utilization Management (UM) decision makers do not encourage decisions that result in underutilization.

For Pharmacy Prior Authorizations:

Prior Authorization for drugs may be requested by you or your provider. All decisions are made within 24 hours of receipt of the PA request unless more information is needed.

- If more information is needed, we will make a final decision within seven working days from the date of request.

If the letter is not clear to you, or the words are hard to read or the letters are too small, please call Member Services for help. You can ask that the notice be rewritten. If Care1st does not explain the letter clearly enough so that you know what it means, you may call AHCCCS, Division of Health Care Management, Medical Management Unit:

- Outside Maricopa County: **1-800-867-5808**

If you disagree with Care1st's decision to deny, reduce, suspend, or terminate a service, you may file an appeal. If you wish to file an appeal, the process is described within the denial notice you got.

Freedom of Choice of Providers

Care1st offers members the freedom to choose providers and specialists in our network. You may change your PCP at any time. You may also choose a different PCP for each family member that is with our plan.

You need to use providers and specialists that are part of the Care1st network. You can find Care1st in-network providers at **care1staz.com** or by calling Member Services at **1-866-560-4042** (TTY/TDD **711**). If you need services from an out-of-network provider, you must have prior authorization to do so. Please call Member Services for help.

Copayments (Also Known as Copays)

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

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

The following persons are not asked to pay copayments:

- People under age 19,
- People determined to be Seriously Mentally Ill (SMI),
- An Individual designated eligible for Children's Rehabilitative Services (CRS) pursuant to as A.A.C Title 9, Chapter 22, Article 13,
- ACC, ACC-RBHA, and CHP members who are residing in nursing facilities or residential facilities such as an Assisted Living Home and only when member's medical condition would otherwise require hospitalization. The exemption from copayments for these members is limited to 90 days in a contract year,
- People who are enrolled in the Arizona Long Term Care System (ALTCS),
- People who are Qualified Medicare Beneficiaries,
- People who receive hospice care,
- American Indian members who are active or previous users of the Indian Health Service, tribal health programs operated under Public Law 93-638, or urban Indian health programs,
- People in the Breast and Cervical Cancer Treatment Program (BCCTP),

- People receiving child welfare services under Title IV-B on the basis of being a child in foster care or receiving adoption or foster care assistance under Title IV-E regardless of age,
- People who are pregnant and throughout postpartum period following the pregnancy, and
- Individuals in the Adult Group (for a limited time**).

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

In addition, copayments are not charged for the following services for anyone:

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

People with optional (non-mandatory) copayments

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

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

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

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

Ask your provider to look up your eligibility to find out what copays you may have. You can also find out by calling Care1st Member Services. You can also check the Care1st website for more information.

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

Optional (Non-Mandatory) Copayment Amounts For Some Medical Services

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

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

People With Required (Mandatory) Copayments

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

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

Required (Mandatory) Copayment Amounts For Persons Receiving TMA Benefits

Service	Copayment
Prescriptions	$2.30
Doctor or other provider outpatient office visits for evaluation and management of your care	$4.00
Physical, Occupational and Speech Therapies	$3.00
Outpatient Non-emergency or voluntary surgical procedures	$3.00

Pharmacists and medical providers can refuse services if the copayments are not made.

5% Limit on All Copayments

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

AHCCCS will track each member's specific copayment levels to identify members who have reached the 5 percent copayment limit. If you think that the total copays you have paid are more than 5 percent of your family's total quarterly income and AHCCCS has

not already told you this has happened, you should send copies of receipts or other proof of how much you have paid to:
AHCCCS
801 E Jefferson St
Mail Drop 4600
Phoenix, AZ 85034

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

RHBA members are exempt from Medicaid copayments.

If You Get a Bill

You should not be billed for a service that is covered by AHCCCS. If you get a bill for a covered service, do not pay the bill. Call the provider who sent you the bill. Tell them that you are an AHCCCS member and ask them to bill Care1st. Give them your ID number and the address and phone number for Care1st. If you get a bill after you have talked to the provider, call Member Services for help.

You may be billed if you ask for a non-covered service and agree in writing to pay for it before you get the service.

Remember to always show your ID card and tell providers that you are a Care1st member before you get services.

If You Have Other Insurance

By law, AHCCCS is the payer of last resort. That means that if you have other health insurance or Medicare, that insurance must be billed first and they must pay their share of cost for services received before AHCCCS does. You should always report changes in your insurance to both AHCCCS and Care1st Member Services. Care1st may help you to pay copayments, coinsurance, or deductibles that you are charged by your other insurance. Care1st will usually not pay for services if your other insurance will pay that service.

When you get services at the pharmacy, your provider, the hospital, or from any other healthcare specialist, always give them the information about both your other health insurance and Care1st.

CRS members under 21 years of age with private insurance or Medicare may use their private insurance or Medicare provider networks to obtain services including those for the CRS condition. Care1st is responsible for all applicable deductibles and copayments.

If you have other primary insurance, your other insurance must pay for any services first.

Dual Eligible – Members with Medicare

Some individuals are eligible for both AHCCCS and Medicare. These individuals are called "Dual Eligible." If you are enrolled in Medicare, Care1st may help pay your Medicare coinsurance and deductibles. Care1st may also help with other costs if you use Care1st providers and your provider follows all of the Care1st rules for cost sharing.

As your secondary insurance, Care1st also pays for behavioral health services copayments, Medicare deductibles, and some services not covered by Medicare. Our Care1st Member Services team is here to help if you have questions about behavioral health services or providers. See the Behavioral Health Services section.

However, AHCCCS or Care1st does NOT pay for any drugs paid by Medicare Part D or for the cost sharing (coinsurance, deductibles and copayments) for these drugs. See the Pharmacy Services section.

If you are enrolled with a Medicare Managed Care Plan (HMO), you should find a PCP that is a part of both your Medicare HMO and Care1st's provider network. You should also use a Care1st provider for other services that you get. Care1st may help pay for services that are covered by AHCCCS and are given by a Care1st provider. Remember, if you want Care1st to help with the cost of your services, you must use Care1st providers.

There is also a special group of Dual Eligible members called Qualified Medicare Beneficiaries (QMBs). QMB members may get more help with coinsurance and deductibles for services that are not usually covered by AHCCCS, and/or are not given by a Care1st provider.

In most cases, AHCCCS and Care1st do not cover prescription drugs for members that are Dual Eligible. This is because these drugs are covered by Medicare Part D. Medicare Part D offers prescription drug coverage to everyone with Medicare. To get Medicare drug coverage, you must be enrolled in a Medicare Advantage health plan that offers a Medicare drug benefit, or a Medicare Part D Plan, which adds drug coverage to Original Medicare. If you have questions or need more information about coverage for prescription drugs call Member Services. If you have questions on whether Care1st can help you pay for a service, call Member Services for help.

Medicaid does not cover medications that are eligible for coverage under Medicare Part D plans. Medicaid does not pay for Medicare copayments, deductibles or cost sharing for Medicare Part D medications except for persons who have been designated to have an SMI designation. AHCCCS covers medications that are excluded from coverage under Medicare Part D when those covered medications are deemed medically necessary. An excluded drug is a medication that is not eligible for coverage under Medicare Part D. AHCCCS may cover some medications that are Over-the-Counter (OTC). Refer to the Care1st OTC Drug List for a list of products available on our website at **care1staz.com** or call Member Services at **1-866-560-4042** (TTY/TDD **711**) to request a printed copy.

For members with a SMI designation, AHCCCS also covers copayments for drugs used for a behavioral health diagnosis when medically necessary and cost effective.

Service Authorization & Medication Request Timeframes

Some services must be reviewed and approved (prior authorized) by Care1st. Some examples are MRIs, pain management, and inpatient procedures/surgery. The Care1st Prior Authorization Guidelines are at **care1staz.com**. Your provider sends a request for prior authorization to Care1st for the service being requested. Care1st, per AHCCCS standards, has up to 72 hours to process an expedited (urgent) request and up to 14 calendar days for a standard (routine) request. Care1st uses nationally recognized criteria when making prior authorization decisions. These criteria are available to you upon request.

If Care1st denies a routine service requested by your provider, Care1st will send you a notice as soon as possible, but no later than 14 calendar days after we get the authorization request from your provider. If Care1st has not reached a decision by day 14, an extension may be requested if it is in the best interest of the member. Care1st may extend the time frame to make a decision by up to 14 calendar days, not to exceed the 28th day from the service request date. The notice also gives you your rights on what you can do if you do not agree with that decision.

If Care1st denies an expedited service requested by your provider, Care1st will send you a notice within 72 hours of our decision and tell you why the request was denied. If Care1st has not reached a decision within 72 hours, an extension may be requested if it is in the best interest of the member. Care1st may extend the time frame to make a decision by up to 14 calendar days, not to exceed the 17th day from the service request date.

You will get a notice if we need an extension. The notice also gives you your rights on what you can do if you do not agree with the decision.

If Care1st reduces, suspends, or terminates a service, Care1st will send you a Notice of Adverse Determination letter at least 10 calendar days before your services are reduced, suspended, or terminated. The exceptions to this are in cases of fraud, if you have moved out of state, or you have requested the service be stopped. You have the right to file a complaint with Care1st regarding the adequacy of the Notice of Adverse Determination letter.

For Pharmacy Prior Authorizations:

Prior authorization for drugs may be requested by you or your provider. All decisions are made within 24 hours of receipt of the PA request unless more information is needed.

- If more information is needed, we will make a final decision within seven working days from the initial date of request.

If the letter is not clear to you, or the words are hard to read or the letters are too small, please call Member Services for help. You can ask that the notice be rewritten. If Care1st does not explain the letter clearly enough so that you know what it means, you may call AHCCCS, Division of Health Care Management, Medical Management Unit:

- Outside Maricopa County: **1-800-867-5808**

If you disagree with Care1st's decision to deny, reduce, suspend, or terminate a service, you may file an appeal. If you wish to file an appeal, the process is described within the denial notice you got.

Grievances (Complaints) – For ACC Members

If you have a grievance (complaint) or any type of a problem with your healthcare services Care1st wants to know.

It is very important that we know your concerns so we can improve service. If you have had a problem or do not think that you have been treated the way you should have been, you can file a grievance by calling Member Services at **1-866-560-4042**. You may also put your grievance in writing and mail it to:
Care1st Health Plan
Attn: Member Services
1850 W Rio Salado Parkway
Suite 211
Tempe, AZ 85281

We will make every effort to help you. We will address your grievance (complaint) as quickly as possible. In most cases, Care1st will resolve your grievance within 10 business days of receipt. All grievances will be resolved within 90 days. You have the right to call AHCCCS at **1-800-867-5808** if Care1st does not resolve the issue for you. You have the right to contact AHCCCS Medical Management at **MedicalManagement@azahcccs.gov** if Care1st does not resolve your concern with the Notice of Adverse Determination letter you got. You may have to pay the cost of services provided while the appeal or State Fair Hearing is pending.

Appeals and Requests For Hearing – For ACC Members

An appeal is a request for review of an action. You have the right to appeal a Care1st decision or action if you believe that it is wrong. Care1st and our providers cannot take punitive action against individuals who file an appeal. You may appeal if Care1st:

- Does not approve a service, including the type or level of service, that was asked for by your provider
- Reduces, suspends, or terminates a service that has already been approved
- Fails to give services in a timely manner, or
- Fails to act within required time frames

If services are reduced, suspended, or terminated, you may ask to continue getting your services during the appeal process. However, if AHCCCS agrees with the Care1st decision about changing your services, you may have to pay for the services you got during the appeal process. To have services continued during this process, you must ask within 10 days of receiving the reduction, suspension, or termination letter from Care1st.

Care1st must get your appeal within 60 days from the date of our decision. Anyone can file an appeal for you if you give that person written permission. To file an appeal, please write to:

Care1st Health Plan
Attn: Appeals Department
1850 W Rio Salado Parkway
Suite 211
Tempe, AZ 85281

Or you may call Member Services at the number listed on the bottom of this page to file your appeal.

There are two types of appeals that can be filed:

Standard appeals can take up to 30 days to resolve. Fourteen extra days (an extension) may be taken if it is needed or it is in your best interest. Once we get your standard appeal, we will send you a letter within five days acknowledging receipt. Please keep that letter and refer to the appeal number if you need to contact us about your appeal.

Expedited appeals happen when either you or your provider (appealing for you and with your written permission) tells us that waiting for a standard appeal to be resolved would put your health at serious risk. Expedited appeals must be resolved within 72 hours. Whether or not an expedited appeal can be filed depends on your medical condition. Once we get your expedited appeal, we will send you a letter within one day acknowledging receipt. Please keep that letter and refer to the expedited appeal number if you need to contact us about your appeal. If you file an expedited appeal but your health condition(s) do not qualify for it to be considered expedited, we will notify you that it is not accepted as expedited and will then treat your appeal as a standard appeal.

Standard and Expedited appeals may also be filed by a provider on your behalf. You must give your provider your written permission to file an appeal on your behalf. If a provider fails to supply Care1st with the written permission, Care1st will send you an appointment of representative form (AOR) for you to sign and return within 30 days of the date the appeal was filed. Once the AOR is received the appeal can be worked. If you fail to sign and return the AOR form, the appeal will be denied for lack of the written permission.

You may ask to review the information we have in your appeal file at any time. If you wish to do so, please call Care1st Member Services and ask to speak with the Appeals Department to schedule a meeting time. Take an active role in your appeal by making sure we have all the facts about your case such as additional statements or medical records.

Care1st will send you our decision about your appeal in writing. Our letter will tell you our decision and how we came to that decision, including rules or laws we used. If you are not happy with our decision you have the right to ask for a hearing by following the steps in the decision letter. A judge who does not work for Care1st or AHCCCS will hear your case and make a recommendation to AHCCCS.

If you want to request a hearing, you must write out your request and send it to us within 90 days of your receipt of our decision letter. Instructions for requesting a hearing are included in our decision letter. If you ask for a hearing, AHCCCS will set up a hearing and let you know the date, time, and place for the hearing. Care1st provides help to members for filing appeals or requests for hearings. Assistance includes use of a toll-free number, i.e., **1-866-560-4042** (TTY/TDD **711**). Members can get translation services at no cost.

You have the right to contact AHCCCS Medical Management at **MedicalManagement@azahcccs.gov** if Care1st does not resolve your concern of adequacy with the Notice of Adverse Determination letter you got.

You have the right to designate a Health Care Decision Maker (HCDM), who can submit concerns on your behalf. These concerns may include, but are not limited to:

- The inability to receive health care services,
- Concerns about the Quality of Care (QOC) received,
- Issues with health care providers,
- Issues with health plans, or
- Timely access to services.

If you are not satisfied with your crisis services care, provider, or Regional Behavioral Health Authority (RBHA) Plan, you may call Care1st to file a complaint or grievance. If a crisis service is denied or partially denied, you may also file an appeal with Care1st. If Care1st's appeal decision does not change, you may file a State fair hearing request with Care1st. To learn more about crisis services grievances, appeals, or State fair hearings, please call Care1st Member Services.

Grievances (Complaints) – For SMI Members

If you have a grievance (complaint) or any type of a problem with your healthcare services Care1st wants to know.

It is very important that we know your concerns so we can improve service. If you have had a problem or do not think that you have been treated the way you should have been, you can file a grievance by calling Member Services at **1-866-560-4042**. You may also put your grievance in writing and mail it to:
Care1st Health Plan
Attn: Member Services
1850 W Rio Salado Parkway
Suite 211
Tempe, AZ 85281

We will make every effort to help you. We will address your grievance (complaint) as quickly as possible. Care1st resolves most grievances within 10 business days of receipt. All grievances will be resolved within 90 days. You have the right to call AHCCCS at **1-800-867-5808** if Care1st does not resolve the issue for you. You have the right to contact AHCCCS Medical Management at **MedicalManagement@azahcccs.gov** if Care1st does not resolve your concern of adequacy with the Notice of Adverse Determination letter you got. SMI members will not be charged for behavioral health services they receive when their appeal is pending, regardless of the results of the appeal.

SMI Grievance

As a member designated with SMI, you have the right to file a SMI grievance if you believe your rights were violated by a mental health provider. You have one year from the date of the alleged rights violation to file a SMI grievance. You can also ask us to look into anything that appears to be dangerous, illegal, or inhumane. Allegations of rights violations by the Tribal Regional Behavioral Health Authority (TRBHA) or its providers, or SMI grievances/requests for an investigation related to physical or sexual abuse or death will be addressed by AHCCCS. Your legal rights include (but are not limited to):

- The right to be free from discrimination
- The right to equal access to behavioral health services
- The right to privacy

- The right to be informed
- The right to get help from an attorney or representative of your choosing

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

If you feel your rights have been violated or want us to look into something, please call Care1st Member Services at **1-866-560-4042** (TTY/TDD **711**). We're happy to help you.

SMI Complaint

As a member designated with SMI, you may file an SMI complaint about anything you are not happy with. It is very important that we know your concerns so we can improve our service. If you have had a problem or do not think that you have been treated the way you should have been, you can file an SMI complaint by calling Member Services at **1-866-560-4042** (TTY/TDD **711**). You may also put your complaint in writing and mail it to:

Care1st Health Plan
Attn: Member Services
1850 W Rio Salado Parkway
Suite 211
Tempe, AZ 85281

We will address your complaint as quickly as possible. You may file a complaint at any time. You may also file a complaint and an SMI grievance at the same time. You do not need to first file a complaint and wait for an answer before you file an SMI grievance.

We will make every effort to help you.

Appeals and Requests For Hearing – For SMI Members

An appeal is a request for review of an action. You have the right to appeal a Care1st decision or action if you believe that it is wrong. If you get a Notice of Adverse Benefit Determination, you have the right to file an appeal. A Notice of Adverse Benefit Determination is a written letter that explains a decision about your services. Even if you did not get a Notice of Adverse Benefit Determination, you may have the right to file an appeal.

Care1st must get your appeal within 60 days from the date of our decision. Anyone can file an appeal for you if you give that person written permission. To file an appeal, please write to:
Care1st Health Plan
Attn: Appeals Department
1850 W Rio Salado Parkway
Suite 211
Tempe, AZ 85281

Or you may call Member Services at the number listed on the bottom of this page to file your appeal.

There are two types of appeals that can be filed:

Standard appeals can take up to 30 days to resolve. Fourteen extra days (an extension) may be taken if it is needed or it is in your best interest. Once we get your standard appeal, we will send you a letter within five days acknowledging receipt. Please keep that letter and refer to the appeal number if you need to contact us about your appeal.

Expedited appeals happen when either you or your provider (appealing for you and with your written permission) tells us that waiting for a standard appeal to be resolved would put your health at serious risk. Expedited appeals must be resolved within 72 hours. Whether or not an expedited appeal can be filed depends on your medical condition. Once we get your expedited appeal, we will send you a letter within one day acknowledging receipt. Please keep that letter and refer to the expedited appeal number if you need to contact us about your appeal. If you file an expedited appeal, but your health condition(s) do not qualify for it to be considered expedited, we will notify you that it is not accepted as expedited and will then treat your appeal as a standard appeal.

Standard and Expedited appeals may also be filed by a provider on your behalf. You must give your provider your written permission to file an appeal on your behalf. If a provider fails to supply Care1st with the written permission, Care1st will send you an appointment of representative form (AOR) for you to sign and return within 30 days of the date the appeal was filed. Once the AOR is received the appeal can be worked. If you fail to sign and return the AOR form, the appeal will be denied for lack of the written permission.

You may ask to review the information we have in your appeal file at any time. If you wish to do so, please call Care1st Member Services and ask to speak with the Appeals Department to schedule a meeting time. Take an active role in your appeal by making sure we have all the facts about your case such as additional statements or medical records.

Care1st will send you our decision about your appeal in writing. Our letter will tell you our decision and how we came to that decision, including rules or laws we used. If you are not happy with our decision you have the right to ask for a hearing by following the steps in the decision letter. A judge who does not work for Care1st or AHCCCS will hear your case and make a recommendation to AHCCCS.

If you want to request a hearing, you must write out your request and send it to us within 90 days of your receipt of our decision letter. Instructions for requesting a hearing are included in our decision letter. If you ask for a hearing, AHCCCS will set up a hearing and let you know the date, time, and place for the hearing. Care1st provides help to members for filing appeals or requests for hearings. Assistance includes use of a toll-free number, i.e., **1-866-560-4042** (TTY/TDD **711**). Members can get translation services at no cost.

You have the right to Contact AHCCCS Medical Management at **MedicalManagement@azahcccs.gov** if Care1st does not resolve your concern of adequacy with the Notice of Adverse Determination letter you got.

As a member designated with SMI, you have the right to appeal the following:

- A decision regarding fees or waivers
- The denial, reduction, suspension, or termination of any covered service
- The ability to make decisions, need for a guardian or other protective services, or need for special assistance
- **Your SMI designation
- **A decision that you no longer need SMI services
- A PASRR determination in the context of either a preadmission screening or an annual resident review, which adversely affects the person

If you file an appeal, you will get written notice within five business days of Care1st receiving the appeal. For an appeal that needs to be expedited, you will get written notice that we got your appeal within one business day of receipt, and the informal conference must occur within two business days of filing the appeal.

If you file an appeal, you will keep getting any behavioral health services that you were already getting unless a qualified clinician decides that reducing or terminating services is best for you, or if you agree in writing to reducing or terminating services. Care1st Health Plan will not make you pay for the services you get during the appeal process, no matter the outcome of the appeal.

Care1st will acknowledge and make a decision about your appeal just like we do other types of appeals. However, you will also have the right to meet with us face-to-face to discuss your appeal. This is called an informal conference. You will have an informal conference with Care1st within 7 business days of filing the appeal. The informal conference must happen at a time and place that is convenient for you. You have the right to have a representative of your choice with you at the conference. You and any other participants will be informed of the time and location of the conference in writing at least 2 business days before the conference. If you are unable to come to the conference in person, you can participate in the conference over the phone.

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

If there is no resolution of the appeal during the second informal conference, or if you asked that the second informal conference be skipped, you will be given information that will tell you how to ask for a State Fair Hearing.

If you file an appeal you will continue to get any services you were already getting unless a qualified clinician decides that reducing or terminating services is best for you, or you agree in writing to reducing or terminating services. If the appeal is not decided in your favor, Care1st may not require you to pay for the services you got during the appeal process.

Solari is the statewide provider that performs Serious Mental Illness (SMI) determinations. If you wish to appeal your SMI determination status, you can do so by calling Solari at **1-800-203-CARE (**2273**). Solari will tell you how to appeal the SMI determination.

You may also contact Solari in writing and mail to:
Solari, Inc.
1275 W Washington St
Suite 210
Tempe, AZ 85281

Grievances (Complaints) – For Non-Title XIX/XXI Nor SMI Members

If you have a grievance (complaint) or any type of a problem with your healthcare services Care1st wants to know.

It is very important that we know your concerns so we can improve service. If you have had a problem or do not think that you have been treated the way you should have been, you can file a grievance by calling Member Services at **1-866-560-4042**. You may also put your grievance in writing and mail it to:
Care1st Health Plan
Attn: Member Services
1850 W Rio Salado Parkway
Suite 211
Tempe, AZ 85281

We will make every effort to help you. We will address your grievance (complaint) as quickly as possible. Care1st will resolve your grievance within 10 business days of receipt, absent extraordinary circumstances. All grievances will be resolved within 90 days. You have the right to call AHCCCS at **1-800-867-5808** if Care1st does not resolve the issue for you. You have the right to contact AHCCCS Medical Management at **MedicalManagement@azahcccs.gov** if Care1st does not resolve your concern of adequacy with the Notice of Adverse Determination letter you got. You may be required to pay the cost of services provided while the appeal or State Fair Hearing is pending.

Appeals And Requests For Hearing – For Non-Title XIX/XXI Nor SMI Members

An appeal is a request for review of an action. You have the right to appeal a Care1st decision or action if you believe that it is wrong. Care1st and our providers cannot take punitive action against individuals who file an appeal. You may appeal if Care1st:

- Does not approve a service, including the type or level of service, that was asked for by your provider
- Reduces, suspends, or terminates a service that has already been approved
- Fails to provide services in a timely manner, or
- Fails to act within required time frames

If services are reduced, suspended, or terminated, you may ask to continue to get your services during the appeal process. However, if AHCCCS agrees with the Care1st decision about changing your services, you may have to pay for the services you got during the appeal process. To have services continued during this process, you must ask within 10 days of receiving the reduction, suspension or termination letter from Care1st.

Care1st must get your appeal within 60 days from the date of our decision. Anyone can file an appeal for you if you give that person written permission. To file an appeal, please write to:

Care1st Health Plan
Attn: Appeals Department
1850 W Rio Salado Parkway
Suite 211
Tempe, AZ 85281

Or you may call Member Services at the number listed on the bottom of this page to file your appeal.

There are two types of appeals that can be filed:

Standard appeals can take up to 30 days to resolve. Fourteen extra days (an extension) may be taken if it is needed or it is in your best interest. Once we get your standard appeal, we will send you a letter within five days acknowledging receipt. Please keep that letter and refer to the appeal number if you need to contact us about your appeal.

Expedited appeals happen when either you or your provider (appealing for you and with your written permission) tells us that waiting for a standard appeal to be resolved would put your health at serious risk. Expedited appeals must be resolved within 72 hours. Whether or not an expedited appeal can be filed depends on your medical condition. Once we get your expedited appeal, we will send you a letter within one day acknowledging receipt. Please keep that letter and refer to the expedited appeal number if you need to contact us about your appeal. If you file an expedited appeal, but your health condition(s) do not qualify for it to be considered expedited, we will notify you that it is not accepted as expedited and will then treat your appeal as a standard appeal.

Standard and Expedited appeals may also be filed by a provider on your behalf. You must give your provider your written permission to file an appeal on your behalf. If a provider fails to supply Care1st with the written permission, Care1st will send you an appointment of representative form (AOR) for you to sign and return within 30 days of the date the appeal was filed. Once the AOR is received the appeal can be worked. If you fail to sign and return the AOR form, the appeal will be denied for lack of the written permission.

You may request to review the information we have in your appeal file at any time. If you wish to do so, please call Care1st Member Services and ask to speak with the Appeals Department to schedule a meeting time. Take an active role in your appeal by making sure we have all the facts about your case such as additional statements or medical records.

Care1st will send you our decision about your appeal in writing. Our letter will tell you our decision and how we came to that decision, including rules or laws we used. If you are not happy with our decision you have the right to ask for a hearing by following the steps in the decision letter. A judge who does not work for Care1st or AHCCCS will hear your case and make a recommendation to AHCCCS.

If you want to request a hearing, you must write out your request and send it to us within 90 days of your receipt of our decision letter. Instructions for requesting a hearing are included in our decision letter. If you ask for a hearing, AHCCCS will set up a hearing and let you know the date, time, and place for the hearing. Care1st provides help to members for filing appeals or requests for hearings. Assistance includes use of a toll-free number, i.e., **1-866-560-4042** (TTY/TDD **711**). Members can get translation services at no cost.

You have the right to Contact AHCCCS Medical Management at **MedicalManagement@azahcccs.gov** if Care1st does not resolve your concern of adequacy with the Notice of Adverse Determination letter you got.

Member Rights

As a Care1st member you have certain rights.

You have a right to:

1. Members who are determined to have a Serious Mental Illness and who are enrolled in one plan for both physical health and behavioral health services may request a different plan for their physical health services. This is called an opt-out request. An opt-out will only be approved if the member or their designee is able to show harm or unfair treatment in:
   - **a.** Getting healthcare,
   - **b.** Receiving quality healthcare,
   - **c.** Protecting member privacy and rights, or
   - **d.** Choosing a provider.

If you would like to ask for an opt-out, contact Member Services at **1-866-560-4042** (TTY/TDD **711**).

Care1st complies with all federal and state laws, including: Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80, The Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91, The Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972 (regarding education programs and activities), Titles II and III of the Americans with Disabilities Act; and section 1557 of the Patient Protection and Affordable Care Act.

2. File a complaint or an appeal about the managed care organization or network providers. Complaints and appeals can be filed with Care1st or AHCCCS.
3. Get information on the structure and operation of Care1st or its subcontractors.
4. Get information on whether or not Care1st has Physician Incentive Plans (PIP) that affect the use of referral services, the right to know the types of compensation arrangements the Contractor uses, the right to know whether stop-loss insurance is needed, and the right to a summary of member survey results, in accordance with PIP regulation.
5. Get polite and courteous care. You will be treated fairly and with respect no matter your race, ethnicity, national origin, gender, age, religion, behavioral health condition (intellectual) or physical disability, sexual preference, genetic information, ability to pay, or ability to speak English.
6. Confidentiality and confidentiality limitations. See Notice of Privacy Practices for details.
7. To help arrange and pay for your care, there are times when your information is shared without first getting your written permission. These times could include the sharing of information with:
    1. Physicians and other agencies providing health, social, or welfare services;
    2. Your medical primary care provider;
    3. Certain state agencies and schools following the law, involved in your care and treatment as needed; and
    4. Members of the clinical team in your care.

8. At times, it may be helpful to share your personal health information with other agencies, such as schools. Your written permission may be needed before your information is shared.
   - There may be times that you want to share your health information with other agencies or certain individuals who may be helping you. In these cases, you can sign an Authorization for Release of Information Form, which states that your medical records, or certain limited portions of your medical records, may be released to the individuals or agencies that you name on the form. For more information on the Authorization for the Release of Information Form, call Care1st Health Plan at **1-866-560-4042** (TTY/TDD **711**) or visit our website at **care1staz.com**. See Notice of Privacy Practices for details.
9. Get a second opinion at no cost to you from another Care1st healthcare professional or from someone outside the network if the Care1st network is not sufficient.
10. Discuss treatment options, regardless of cost or benefit coverage, presented in a manner appropriate to your condition and ability to understand the information.
11. Get information about formulating Advance Directives.
12. Ask for a copy of your medical records annually at no cost to you.*
13. Inspect your medical records at no cost to you.
14. Get a reply within 30 days to your request for a copy of your records.**
15. Ask that your medical records be updated or corrected.
16. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
17. Get information on beneficiary and plan information, the organization, services, practitioners and providers as well as member rights and responsibilities.
18. Be treated with respect and with due consideration for your dignity and privacy.
19. Participate in decisions regarding your healthcare, refuse any medical treatments, and to be told what will happen if you do not get treatment.
20. Be given information about Care1st providers, including their qualifications and the languages other than English that they speak.
21. Use any hospital or other setting for emergency care.
22. Have your medical records and any information about your health care be private and confidential.

23. Choose your PCP from Care1st's list of PCPs. You also have the right to change PCPs if you wish to do so.

24. Get services in a language that you understand at no cost to you. You have the right to get an interpreter if you have limited English or if you are hearing impaired.

25. Know and understand your medical problems and healthcare conditions so that you can make informed decisions about your healthcare. Ask and be told the cost you would pay if you chose to pay for a service that Care1st does not cover.

26. Get a summary of Care1st's member survey results.

27. Be told in writing of any changes to your services.

28. Be told in writing when Care1st reduces, suspends, terminates, or denies any service requested by a provider. Be told what to do if you do not agree with Care1st's decision.

29. Get a copy of member rights and responsibilities and the right to make recommendations regarding Care1st rights and responsibilities policy.

30. File a complaint with Care1st regarding the adequacy of a Notice of Adverse Determination letter you got. You have the right to Contact AHCCCS Medical Management at **MedicalManagement@azahcccs.gov** if Care1st does not resolve your concern of adequacy with the Notice of Adverse Determination letter you got. (Outside Maricopa County: **1-800-962-6690**)

31. Decide who you want to be at your treatments and exams.

32. Tell Care1st about any problems, complaints, or grievances you have with your healthcare services, your providers, or Care1st.

33. Have available upon request the criteria that decisions are based on. Have your medical records transferred from your previous provider to your new provider within 10 days of your request.

34. Exercise your right and that the exercise of those rights shall not adversely affect service delivery to you [42 CFR 438.100(c)].

*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).

**The response may be the copy of the medical record or a written denial that includes the basis for the denial and information about how to seek review of the denial in accordance with 45 CFR Part 164. (AMPM 410-B9e).

Fraud, Waste and Abuse

Fraud, waste, and abuse are serious problems that require your attention. Most providers are honest and mean well. However, there are some who abuse healthcare programs, such as Medicaid and Medicare. It is very important that Care1st members report any cases of suspected fraud and abuse.

Abuse (of a member): An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable State or Federal law.

Abuse (by a provider): Provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the AHCCCS program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare. It also includes recipient practices that result in unnecessary cost to the AHCCCS program.

Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable State or Federal law.

Waste: Generally, this means overuse of services or other practices that result in unnecessary costs. In most cases, waste is not considered caused by reckless actions but rather by the misuse of resources.

An example of provider fraud is a provider billing for services that were not given to you or billing for the same service twice. Abuse happens when a provider's actions (planned or unplanned) cause needless costs to a healthcare program. An example of waste and abuse is a provider billing for services that are not medically necessary. Abuse can also happen when a provider touches you or talks to you in a bad way.

If you know of any fraud that has occurred, call our 24-hour fraud hotline. It's private. The toll-free number is **1-866-685-8664**. The hotline is staffed 24 hours per day, seven days per week. You can remain anonymous. If you do give us a telephone number, we'll call to make sure the information we have is complete and accurate.

You can also report fraud directly to AHCCCS by calling **1-888-487-6686** or by going to the AHCCCS website at **www.azahcccs.gov/Fraud/ReportFraud**.

You should also report any cases of suspected member fraud and abuse. Members commit fraud by cheating or lying (on purpose) to a healthcare program, such as AHCCCS or Medicare, in order to obtain a service or benefit at the government's expense. Members commit abuse when their actions cause loss of money to a healthcare program. There are penalties under the law for committing fraud and abuse, such as criminal and/or civil charges. An example of member fraud is a member sharing an AHCCCS ID card with others. Another example is an AHCCCS member that does not report having other insurance. If you think you know of member fraud, call or write the Compliance Department at the number or address above.

AHCCCS attaches photos of members on the web tool that providers use to see if a member is eligible. The photos are one of many efforts by AHCCCS to help protect members and stop fraud. AHCCCS gets the photos from the Motor Vehicle Division (MVD) if you have an Arizona driver's license or state ID card. When providers pull up the AHCCCS eligibility verification screen, they will see your picture (if available) with your coverage details.

Tobacco Cessation

There are many health risks from smoking. If you are over the age of 18 and are ready to stop using tobacco, help is available. Call the Arizona Smokers Helpline through the Arizona Department of Health Services (ADHS) at **1-800-556-6222** to enroll. You can also visit **www.ashline.org** or **https://azdhs.gov/prevention/tobacco-chronic-disease/tobacco-free-az**.

You will be paired with a coach who will give you education and support through weekly telephone calls. ASHLine coaches will help you select a nicotine replacement therapy (NRT) and guide you through the process of getting NRT at your local pharmacy.

Community Resource List

Care1st works with community groups to give you high quality healthcare. Please visit **care1staz.com** for more information.

Name	Web Address	Phone
2-1-1 (Referral & Information Helpline)	**www.211arizona.org**	**211**
Alzheimer's Association	**www.alz.org**	**1-800-272-3900**

Name	Web Address	Phone
American Academy of Pediatrics (AAP)	**www.aap.org**	**1-800-433-9016**
American Diabetes Association	**www.diabetes.org**	**1-800-342-2383**
American Lung Association	**www.lung.org**	**1-800-586-4872**
Area Agency on Aging	**www.aaaphx.org** **https://nacog.org/** **www.wacog.com/area-agency-on-aging/** **http://www.pgcsc.org/**	Maricopa: **602-264-4357** or **1-888-783-7500** Apache, Coconino, Navajo, and Yavapai: **1-877-521-3500** Mohave: **928-753-7038** Gila and Pinal: **1-800-293-9393**
Arizona@Work	**https://arizonaatwork.com/**	
Arizona Center for Disability Law (ACDL)	**www.azdisabilitylaw.org**	**1-800-927-2260**
Arizona Coalition Against Sexual and Domestic Violence (ACESDV)	**www.acesdv.org**	**1-800-782-6400**
Arizona Department of Economic Security Aging and Disability Resource Center	**www.azlinks.gov**	
Arizona Department of Health Services	**www.azdhs.gov**	**602-542-1025**
ADHS Pregnancy and Breastfeeding Hotline	**https://azdhs.gov/prevention/nutrition-physical-activity/breastfeeding/index.php**	**1-800-833-4642**

Care1st Health Plan Arizona

Name	Web Address	Phone
Arizona Early Intervention Program (AzEIP)	**https://des.az.gov/services/disabilities/developmental-infant**	**602-532-9960**
Arizona Family Health Partnership	**www.arizonafamilyhealth.org**	**602-258-5777**
Arizona Health Care Cost Containment System (AHCCCS)	**www.AZAHCCCS.gov**	**602-417-7000** or **1-800-962-6690**
Arizona Smokers' Helpline (ASHLine)	**www.ashline.org**	**1-800-556-6222**
Arizona Suicide Prevention Coalition	**www.azspc.org**	**480-784-1500** or **1-800-273-8255**
Arizona Department of Economic Security (DES), (Family Assistance Administration)	**www.azdes.gov/faa**	**1-855-777-8590**
Arizona Youth Partnership Starting Out Right Program	**https://azyp.org/program/starting-out-right/**	**1-877-882-2881**
AZ Links	**www.azlinks.org https://azdaars.getcare.com/consumer/**	
Childhelp National Child Abuse Hotline	**www.childhelp.org.**	**1-800-4-A-CHILD** or **1-800-422-4453**
Children's Information Center Hotline		**1-800-232-1676**
Dental – Reduced Fee and Community Dental Clinics in Arizona	**https://www.azdhs.gov/documents/prevention/womens-childrens-health/oral-health/reduced-fee-dental-clinics.pdf**	See list for locations/ phone numbers

Name	Web Address	Phone
Disability Benefits 101	**https://az.db101.org/**	**1-866-304-WORK (9675)**
Dump the Drugs AZ (Disposing of unused or unwanted prescription drugs)	**https://azdhs.gov/gis/dump-the-drugs-az/**	
Federal Health Insurance Marketplace	**www.healthcare.gov**	**1-800-318-2596**
Fussy Baby/Birth To Five Helpline	**https://www.swhd.org/programs/health-and-development/fussy-baby/**	**1-877-705-KIDS** or **1-877-705 5437**
Head Start	**www.azheadstart.org**	Maricopa: **602-338-0449** Apache, Coconino, Navajo and Yavapai: **928-774-9504** Gila and Pinal: **1-888-723-7321** Mohave: **928-782-1886**
Health-e-Arizona Plus	**www.healthearizonaplus.gov**	**1-855-432-7587**
Immunization Information	**https://www.azdhs.gov/preparedness/epidemiology-disease-control/immunization/index.php**	**602-542-1025**
Mentally Ill Kids in Distress (MIKID)	**www.mikid.org**	Gila, Maricopa and Pinal: **602-253-1240** Apache, Coconino, Mohave, Navajo and Yavapai: **928-775-4448**

Name	Web Address	Phone
Mercy Care (RBHA)	**www.mercycareaz.org**	Gila, Maricopa and Pinal: **1-800-564-5465**
National Alliance on Mental Illness (NAMI)	**www.nami.org**	**1-800-950-6264**
National Suicide Prevention Lifeline	**https://suicidepreventionlifeline.org/**	**1-800-273-TALK (8255)**
Office for Children with Special Needs (OCSHCN)	**https://www.azdhs.gov/prevention/womens-childrens-health/ocshcn/index.php**	**602-542-1860** or **1-800-232-1676**
Opioid Assistance & Referral	**https://www.azdhs.gov/oarline/**	**1-888-688-4222**
Poison Control	**https://azpoison.com/**	**1-800-222-1222**
Postpartum Support International	**https://www.postpartum.net/**	**1-800-944-4773** or Text: English: **1-800-944-4773** Español: **971-203-7773**
Power Me A2Z	**www.powermea2z.org**	
Raising Special Kids	**www.raisingspecialkids.org**	**602-242-4366** or **1-800-237-3007**
Sliding Fee Schedule Clinics (no cost or low cost)	**https://www.azdhs.gov/prevention/health-systems-development/sliding-fee-schedule/index.php**	**602-542-1219**
St. Vincent De Paul Dental Clinics (Maricopa County)	**www.stvincentdepaul.net**	**602-261-6868**
Strong Families AZ	**https://strongfamiliesaz.com/**	Visit the website and enter the ZIP code to find a program near you
Teen Life Line	**https://teenlifeline.org/**	**602-248-8336 (TEEN)** or **1-800-248-8336 (TEEN)**

Name	Web Address	Phone
Tobacco Free Arizona	**https://www.azdhs.gov/prevention/tobacco-chronic-disease/tobacco-free-az/index.php**	**1-800-556-6222**
Vocational Rehabilitation	**https://des.az.gov/services/employment/rehabilitation-services/vocational-rehabilitation**	**1-800-563-1221**
Women Infant and Children (WIC)	**www.azdhs.gov/prevention/azwic/**	**1-800-252-5942**

If You Become Ineligible For Medicaid

If you become ineligible for Medicaid and are not able to get other health insurance, you can visit this website to look for clinics that give primary, mental, and dental health services at low or no cost to people without health insurance.

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

Interoperability and Patient Access Rule: New Ways to Manage Your Digital Health Records

New Ways to Manage Your Digital Health Records

On July 1, 2021, a new federal rule called the Interoperability and Patient Access Rule (CMS 9115 F) went into effect. This rule makes it easier for members to get their health records when they need them most.

You now have full access to your health records on your mobile device, such as your smartphone, which lets you manage your health better and know what resources are open to you.

Imagine...

- Going to a new provider because you don't feel well, and that provider being able to pull up your health history from the past five years

- Using an up-to-date provider directory to find a provider or specialist
- Having access to your health history so a provider or specialist can quickly diagnose you and make sure you get the best care
- Seeing if your claim has been paid, denied, or is still being processed right from your computer
- Being able to take your health history with you if and when you switch health plans*

**In 2022, members can start requesting that their health records go with them if they switch health plans.*

In addition, the new rule makes it easier to find information on:**

- Claims (paid and denied)
- Specific parts of your clinical information
- Pharmacy drug coverage
- Healthcare providers

**You can get information for dates of service on or after January 1, 2016.

For more information, contact Member Services.

Advance Directives – Decisions About Your Healthcare

Reference: Arizona Secretary of State – **www.azsos.gov**

You are getting this information about your rights to make or control your own healthcare decisions in accordance with the Patient Self Determination Act (PSDA). Care1st hopes this information is helpful to you in making important decisions about your healthcare.

Fewer than 25% of Americans have written down how they wish to be cared for at the end of their lives. Most people avoid talking about the subject. Planning ahead now by completing an advance directive helps make your wishes known about what you do and do not want when you cannot speak for yourself. This will ease the stress on your family and loved ones when the time comes.

The most important thing you can do to ensure that the healthcare decisions you have made in advance are followed is to talk about them. Talk to your family, friends, neighbors, clergy, doctors, and other healthcare providers. Let them know what you have

decided, what your values and preferences are, and what you do and do not want when you cannot speak for yourself.

If you have completed an advance directive, you still remain in control of your healthcare decisions as long as you are able to communicate your wishes.

If you have questions about advance directives, please call the Office of the Arizona Secretary of State Advance Directive section at **1-877-458-5842** or visit **www.azsos.gov**. You can find the forms you will need to complete your advance directive at this website.

You can also store a copy of your advance directive in Arizona's Advance Health Care Directive Registry so it is available in an emergency. You can get information about storing a copy of your advance directive in Arizona's Advance Health Care Directive Registry at **www.azsos.gov** or you can call **1-877-458-5842**.

1. **What is an Advance Directive?**
   An Advance Directive is a document in which you give instructions about your healthcare and what you want done or not done if you can't speak for yourself.
2. **What is a Health Care Directive?**
   A Health Care Directive is a type of Advance Directive that tells your provider and your family members what kind of care you would like to have if you become unable to make medical decisions. It's called an "advance directive" because you choose your medical care before you become seriously ill.
3. **What is a Living Will?**
   A Living Will is one form of Advance Directive. It usually only comes into effect if you are terminally ill. Being terminally ill generally means that you have less than six months to live.
4. **What is a Health Care (Medical) Power of Attorney?**
   A Health Care (Medical) Power of Attorney lets you name someone to make medical decisions for you if you are unconscious or unable to make medical decisions for yourself for any reason. A Health Care (Medical) Power of Attorney can be part of another advance directive form, such as a Health Care Directive or Living Will, or may be a separate document. The person you appoint to make decisions for you when you cannot is called an "agent."
5. **Does an agent appointed in a Health Care (Medical) Power of Attorney need to be a resident of the state in which you live?**
   No, but they need to be available if a medical crisis occurs.

6. **What training does a person need to become a Health Care (Medical) Power of Attorney?**
   None. Your Health Care (Medical) Power of Attorney is not a medically trained person. The person you appoint as your Health Care (Medical) Power of Attorney is a person close to you that you can talk to about your values and feelings. Make sure that the person you appoint is willing to assume the responsibility of being your representative.
7. **Can an Advance Directive and a Health Care (Medical) Power of Attorney be combined into one document?**
   Yes, they often are.
8. **What authority does a Financial or Durable Power of Attorney have to make healthcare decisions?**
   None.
9. **When does an Advance Directive or Health Care (Medical) Power of Attorney become effective?**
   An Advance Directive, including a Health Care (Medical) Power of Attorney, has no legal effect unless and until you lack the capacity to make healthcare decisions or to give consent for care. Neither the appointed Health Care (Medical) Power of Attorney nor a written instruction can override your currently expressed choice.
10. **Must physicians honor Living Wills, Advance Directives, and a healthcare surrogate's decisions?**
    Yes, providers and other healthcare providers are legally obligated to follow your Advance Directive.
11. **What happens if I do not have an Advance Directive?**
    If you do not have an advance directive and you cannot make healthcare decisions, Arizona law gives decision-making power to default decision-makers or "surrogates." These surrogates, who are primarily family members, can make most healthcare decisions.

    The order of people authorized to make healthcare decisions is:

    1. Guardian
    2. Health Care (Medical) Power of Attorney
    3. Surrogate
    4. The patient's spouse, unless legally separated
    5. An adult child of the patient or a majority of adult children

6. A parent of the patient
7. The patient's domestic partner if the patient is unmarried
8. A brother or sister of the patient
9. A close friend of the patient
10. If none of the above can be located, the attending physician, after consulting with an ethics committee. If unavailable, the physician may make these decisions after consulting with a second physician.

12. Is a "surrogate" decision-maker the same as a Health Care (Medical) Power of Attorney?

In Arizona, if you do not appoint a Health Care (Medical) Power of Attorney, a surrogate decision-maker can make most medical decisions for you. However, a surrogate decision-maker cannot decide to remove artificial nutrition that has been started. Legally, only the person, a Health Care (Medical) Power of Attorney, or a guardian can authorize stopping artificial nutrition. The decision to withhold or withdraw any other treatment can be made by any surrogate.

13. What is a Pre-Hospital Directive (sometimes called an Orange Form)?

Emergency medical service personnel (or "**911**" responders) will generally resuscitate and stabilize patients until they are brought safely to a hospital. If needed, you may get cardiopulmonary resuscitation (CPR), which is treatment to try to restart a person's breathing or heartbeat. CPR may be done by pushing on the chest, by putting a tube down the throat or by shocking the heart in an attempt to restart it. If you do not wish to have CPR if your heart stops or if you stop breathing, you must complete a special Advance Directive document called a "Pre-Hospital Directive."

14. What is special about a Pre-Hospital Directive (Orange Form)?

This document must be printed on bright orange paper and states that you do not want CPR to restart your heart or breathing. The Pre-Hospital Directive must be signed by you and must be signed by either your physician or other healthcare provider.

15. If I complete a Pre-Hospital Directive do I need any other Advance Directive?

Yes. The Pre-Hospital Directive has a limited role. The Pre-Hospital Directive is only effective outside of a healthcare institution (at home and in the community); it is not effective in the hospital or other healthcare institution.

16. Do I need a lawyer to complete an Advance Directive?

No. You do not need a lawyer to make an Advance Directive.

17. **Do I need to use a special form?**
    You do not have to use a specific form. Although there is a sample form in Arizona law, you may use any form, as long as it conforms to the law and is properly witnessed.
18. **Must a Health Care (Medical) Power of Attorney or Advance Directive be notarized?**
    In Arizona these documents may be either witnessed or notarized. The witness must know that you signed freely and had the capacity to understand what you were doing. The witness may not be the individual you have named as your agent, someone related to you by blood marriage or adoption, someone who will benefit from your estate, or your healthcare provider. Some states need this document to be notarized. If you plan to travel out of Arizona, you should have these documents notarized when you sign them.
19. **Are Advance Directives written in other states valid in Arizona?**
    Yes, if they conform to the law of the state in which they were prepared and to Arizona law. Witnessing requirements may vary from state to state.
20. **Who should get a copy of my Advance Directive and Health Care (Medical) Power of Attorney?**
    You or your agent should keep the original documents at home (not in a safe deposit box). Give copies to your physician(s), family members, and anyone else you want to know about your wishes. Give a copy to other healthcare personnel, at the emergency room, outpatient clinic, or hospital.
21. **What if I change my mind, or want to change my Directive?**
    You can cancel or change any Advance Directive by telling your agent or healthcare provider in writing of your decision to do so. Destroying all copies of the old one and creating a new one is the best way. Make sure you give a copy of the new one to your physician and anyone else who got the old one. The most recent directive is the legally binding one.
22. **What if I don't have time to change my Directive in writing?**
    If you do not have time to put your changes in writing, you can make them known verbally. Tell your provider and any family or friends present exactly what you want to happen. Wishes that are made in person will be followed in place of the ones made earlier in writing. Be sure your instructions are clearly understood by everyone you have told.

23. **What is a Mental Health Care Power of Attorney?**
    A Mental Health Care Power of Attorney is a document that lets you name someone to make decisions for you related to your mental health if you are unable to make those decisions for yourself.
24. **What is special about a Mental Health Care Power of Attorney?**
    Only a Mental Health Care Power of Attorney or a guardian appointed by the court can authorize your admission to a mental healthcare facility for treatment of mental illness (including dementia with behavioral problems) without your consent.

Members have the right to file a complaint directly with AHCCCS about Advance Directives. To file a complaint regarding advance directives, please contact AHCCCS at:
AHCCCS Member Services
801 E Jefferson St
Phoenix, AZ 85034
602-417-7000 (Outside Maricopa County: **1-800-654-8713)**
E-mail: **MemberServices@azahcccs.gov**

Advocacy Resources

There are groups and organizations that will act as an advocate for you. Advocacy involves direct service to the individual or family as well as activities that promote health and access to healthcare in communities.

An advocate is anyone who supports and promotes the rights of the patient. Examples of health advocacy organizations are listed below:

- **Aging and Disability Resource Centers (ADRC)**
  The Aging and Disability Resource Centers are the main points of access for long-term supports and services for older adults and people with disabilities, including home healthcare and assistive technology. Please visit **www.azlinks.gov** or **https://azdaars.getcare.com/consumer** for more information.
- **Area Agency on Aging**
  The Area Agency on Aging (Maricopa) offers a large variety of programs and services that enhance the quality of life for residents of Arizona. They advocate, plan, coordinate, develop, and deliver services for adults aged 60+, adults aged 18+ with HIV/AIDS, adults aged 18+ with disabilities and long-term care needs, and family caregivers. See the Community Resources List for website and phone information in your county of residence.

- **Arizona Center for Disability Law (ACDL)**
  ACDL is the Arizona state disability protection and advocacy (P&A) agency. It is a not-for-profit public interest law firm that is dedicated to protecting people with a wide range of disabilities. ACDL can be reached at **1-800-927-2260** or **www.azdisabilitylaw.org**
- **Arizona Coalition To End Sexual And Domestic Violence**
  The Arizona Coalition To End Sexual And Domestic Violence was formed in 1980 so that concerned citizens and professionals could unite in a statewide organization to end domestic violence. In 2013, the coalition became the designated dual coalition to address both sexual and domestic violence thus becoming the Arizona Coalition to End Sexual and Domestic Violence. The helpline is open Monday through Friday, 8:30 a.m. to 5 p.m. by calling **602-279-2980** or **www.acesdv.org**.
- **Mental Health America of Arizona**
  Mental Health America of Arizona promotes the mental health and well-being of all Arizonans through education, advocacy, and the shaping of public policy. Mental Health America of Arizona can be reached at **602-214-9507** or **www.mhaarizona.org**.
- **National Alliance on Mental Illness (NAMI)**
  The National Alliance on Mental Illness (NAMI) is the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness. NAMI can be reached at **1-800-950-6264** or **www.nami.org**.
- **National Domestic Violence Hotline**
  The National Domestic Violence Hotline can help victims, survivors of domestic violence. The National Domestic Violence Hotline can be reached at **1-800-799-7233** or **www.thehotline.org**.
- **Office of Human Rights**
  The Office of Human Rights (OHR) primarily serves individuals with a Serious Mental Illness (SMI) determination and designated as Special Assistance in the public behavioral health system to help them understand, protect, and exercise their rights, facilitate self-advocacy through education, and obtain access to behavioral health services. OHR serves the entire state through three offices:
  - Phoenix (serves Gila and Maricopa counties, Gila River Indian Community, as well as Arizona State Hospital): **602-364-4585** or **1-800-421-2124**
  - Flagstaff (serves Apache, Coconino, Mohave, Navajo, and Yavapai counties and White Mountain Apache Tribe and Navajo Nation): **1-928-214-8231** or **1-877-744-2250**

- Tucson (Pima, Cochise, Graham, Greenlee, Santa Cruz, La Paz, and Yuma counties and Pascua Yaqui Tribe): **1-520-770-3100** or **1-877-524-6882**

Note: Tribal members should contact the Office of Human Rights location that provides services to the county they live in (county of residence).

Special Assistance Information For Members With SMI

Special Assistance is a unique clinical designation providing support to members with an SMI determination. Qualifying members must have an inability to communicate and/or participate during treatment planning and have a qualifying mental and/or physical condition. When a health home clinical team or other qualified assessor determines a member meets Special Assistance criteria, they notify the Office of Human Rights. The Office of Human Rights will assign an individual to meet Special Assistance needs who advocates on behalf of the member during treatment planning. Care1st works in collaboration with the AHCCCS Office of Human Rights to ensure members meeting Special Assistance criteria are appropriately identified. You can call the office of Human Rights at **1-800-421-2124** and/or **www.azahcccs.gov/AHCCCS/healthcareadvocacy/ohr.html**.

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. *Please review it carefully.*

Effective 07.01.2017 (revised 07.15.2022)

For help to translate or understand this, please call **1-866-560-4042** (TTY/TDD **711**).

Para obtener ayuda con la traducción o la comprensión de este contenido, llame al **1-866-560-4042** (TTY/TDD **711**).

Interpreter services are provided at no cost to you.

Covered Entities Duties:

Care1st Health Plan Arizona, Inc. (Care1st) is a Covered Entity as defined and regulated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Care1st is required by law to maintain the privacy of your protected health information (PHI), provide you with this Notice of our legal duties and privacy practices related to your PHI, abide by the terms of the Notice that is currently in affect and notify you in the event of a breach of your unsecured PHI.

This Notice describes how we may use and disclose your PHI. It also describes your rights to access, amend and manage your PHI and how to exercise those rights. All other uses and disclosures of your PHI not described in this Notice will be made only with your written authorization.

Care1st reserves the right to change this Notice. We reserve the right to make the revised or changed Notice effective for your PHI we already have as well as any of your PHI we receive in the future. Care1st will promptly revise and distribute this Notice whenever there is a material change to the following:

- The Uses or Disclosures
- Your rights
- Our legal duties
- Other privacy practices stated in the notice

We will make any revised Notices available on the Care1st website located below.

care1staz.com

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Permissible Uses and Disclosures of Your PHI:

The following is a list of how we may use or disclose your PHI without your permission or authorization:

- ***Treatment*** – We may use or disclose your PHI to a physician or other health care provider providing treatment to you, to coordinate your treatment among providers, or to assist us in making prior authorization decisions related to your benefits.
- ***Payment*** – We may use and disclose your PHI to make benefit payments for the health care services provided to you. We may disclose your PHI to another health plan, to a health care provider, or other entity subject to the federal Privacy Rules for their payment purposes. Payment activities may include:
  - Processing claims
  - Determining eligibility or coverage for claims
  - Issuing premium billings
  - Reviewing services for medical necessity
  - Performing utilization review of claims
- ***HealthCare Operations*** – We may use and disclose your PHI to perform our healthcare operations. These activities may include:
  - Providing customer services
  - Responding to complaints and appeals
  - Providing case management and care coordination
  - Conducting medical review of claims and other quality assessment
  - Improvement activities

  In our healthcare operations, we may disclose PHI to business associates. We will have written agreements to protect the privacy of your PHI with these associates. We may disclose your PHI to another entity that is subject to the federal Privacy Rules. The entity must also have a relationship with you for its healthcare operations. This includes the following:
  - Quality assessment and improvement activities
  - Reviewing the competence or qualifications of healthcare professionals
  - Care management and care coordination
  - Detecting or preventing healthcare fraud and abuse
- ***Group Health Plan/Plan Sponsor Disclosures*** – We may disclose your protected health information to a sponsor of the group health plan, such as an employer or other entity that is providing a health care program to you, if the sponsor has agreed to certain restrictions on how it will use or disclose the protected health information (such as agreeing not to use the protected health information for employment-related actions or decisions).

Other Permitted or Required Disclosures of Your PHI:

- ***Fundraising Activities*** – We may use or disclose your PHI for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance their activities. If we do contact you for fundraising activities, we will give you the opportunity to opt-out, or stop, receiving such communications in the future.

- ***Underwriting Purposes*** – We may use or disclose your PHI for underwriting purposes, such as to make a determination about a coverage application or request. If we do use or disclose your PHI for underwriting purposes, we are prohibited from using or disclosing your PHI that is genetic information in the underwriting process.
- ***Appointment Reminders/Treatment Alternatives*** – We may use and disclose your PHI to remind you of an appointment for treatment and medical care with us or to provide you with information regarding treatment alternatives or other health-related benefits and services, such as information on how to stop smoking or lose weight.
- ***As Required by Law*** – If federal, state, and/or local law requires a use or disclosure of your PHI, we may use or disclose your PHI to the extent that the use or disclosure complies with such law and is limited to the requirements of such law. If two or more laws or regulations governing the same use or disclosure conflict, we will comply with the more restrictive laws or regulations.
- ***Public Health Activities*** – We may disclose your PHI to a public health authority for the purpose of preventing or controlling disease, injury, or disability. We may disclose your PHI to the Food and Drug Administration (FDA) to ensure the quality, safety or effectiveness of products or services under the jurisdiction of the FDA.
- ***Victims of Abuse and Neglect*** – We may disclose your PHI to a local, state, or federal government authority, including social services or a protective services agency authorized by law to receive such reports if we have a reasonable belief of abuse, neglect or domestic violence.
- ***Judicial and Administrative Proceedings*** – We may disclose your PHI in judicial and administrative proceedings. We may also disclose it in response to the following:
  - An order of a court
  - Administrative tribunal
  - Subpoena
  - Summons
  - Warrant
  - Discovery request
  - Similar legal request
- ***Law Enforcement*** – We may disclose your relevant PHI to law enforcement when required to do so. For example, in response to a:
  - Court order
  - Court-ordered warrant
  - Subpoena
  - Summons issued by a judicial officer
  - Grand jury subpoena

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

- ***Coroners, Medical Examiners and Funeral Directors*** – We may disclose your PHI to a coroner or medical examiner. This may be necessary, for example, to determine a cause of death. We may also disclose your PHI to funeral directors, as necessary, to carry out their duties.
- ***Organ, Eye and Tissue Donation*** – We may disclose your PHI to organ procurement organizations. We may also disclose your PHI to those who work in procurement, banking or transplantation of:
  - Cadaveric organs
  - Eyes
  - Tissues

- ***Threats to Health and Safety*** – We may use or disclose your PHI if we believe, in good faith, that the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.
- ***Specialized Government Functions*** – If you are a member of U.S. Armed Forces, we may disclose your PHI as required by military command authorities. We may also disclose your PHI:
  - To authorized federal officials for national security
  - To intelligence activities
  - The Department of State for medical suitability determinations
  - For protective services of the President or other authorized persons
- ***Workers' Compensation*** – We may disclose your PHI to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.
- ***Emergency Situations*** – We may disclose your PHI in an emergency situation, or if you are incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previously identified by you. We will use professional judgment and experience to determine if the disclosure is in your best interest. If the disclosure is in your best interest, we will only disclose the PHI that is directly relevant to the person's involvement in your care.
- ***Inmates*** – If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your PHI to the correctional institution or law enforcement official, where such information is necessary for the institution to provide you with health care; to protect your health or safety; or the health or safety of others; or for the safety and security of the correctional institution.
- ***Research*** – Under certain circumstances, we may disclose your PHI to researchers when their clinical research study has been approved and where certain safeguards are in place to ensure the privacy and protection of your PHI.

Uses and Disclosures of Your PHI That Require Your Written Authorization

We are required to obtain your written authorization to use or disclose your PHI, with limited exceptions, for the following reasons:

Sale of PHI – We will request your written authorization before we make any disclosure that is deemed a sale of your PHI, meaning that we are receiving compensation for disclosing the PHI in this manner.

Marketing – We will request your written authorization to use or disclose your PHI for marketing purposes with limited exceptions, such as when we have face-to-face marketing communications with you or when we provide promotional gifts of nominal value.

Psychotherapy Notes – We will request your written authorization to use or disclose any of your psychotherapy notes that we may have on file with limited exception, such as for certain treatment, payment or healthcare operation functions.

Individuals Rights

The following are your rights concerning your PHI. If you would like to use any of the following rights, please contact us using the information at the end of this Notice.

- ***Right to Revoke an Authorization*** – You may revoke your authorization at any time, the revocation of your authorization must be in writing. The revocation will be effective immediately, except to the extent that we have already taken actions in reliance of the authorization and before we received your written revocation.
- ***Right to Request Restrictions*** – You have the right to request restrictions on the use and disclosure of your PHI for treatment, payment or healthcare operations, as well as disclosures to persons involved in your care or payment of your care, such as family members or close friends. Your request should state the restrictions you are requesting and state to whom the restriction applies. We are not required to agree to this request. If we agree, we will comply with your restriction request unless the information is needed to provide you with emergency treatment. However, we will restrict the use or disclosure of PHI for payment or health care operations to a health plan when you have paid for the service or item out of pocket in full.
- ***Right to Request Confidential Communications*** – You have the right to request that we communicate with you about your PHI by alternative means or to alternative locations. This right only applies if the information could endanger you if it is not communicated by the alternative means or to the alternative location you want. You do not have to explain the reason for your request, but you must state that the information could endanger you if the communication means or location is not changed. We must accommodate your request if it is reasonable and specifies the alternative means or location where your PHI should be delivered.
- ***Right to Access and Receive Copy of your PHI*** – You have the right, with limited exceptions, to look at or get copies of your PHI contained in a designated record set. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your PHI. If we deny your request, we will provide you a written explanation and will tell you if the reasons for the denial can be reviewed and how to ask for such a review or if the denial cannot be reviewed.
- ***Right to Amend your PHI*** – You have the right to request that we amend, or change, your PHI if you believe it contains incorrect information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request for certain reasons, for example if we did not create the information you want amended and the creator of the PHI is able to perform the amendment. If we deny your request, we will provide you a written explanation. You may respond with a statement that you disagree with our decision and we will attach your statement to the PHI you request that we amend. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.
- ***Right to Receive an Accounting of Disclosures*** – You have the right to receive a list of instances within the last 6 year period in which we or our business associates disclosed your PHI. This does not apply to disclosure for purposes of treatment, payment, health care operations, or disclosures you authorized and certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. We will provide you with more information on our fees at the time of your request.

- ***Right to File a Complaint*** – If you feel your privacy rights have been violated or that we have violated our own privacy practices, you can file a complaint with us in writing or by phone using the contact information at the end of this Notice.

  You can also file a complaint with the Secretary of the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, or calling **1-800-368-1019**, (TTY **1-800-537-7697**), or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints**.

  WE WILL NOT TAKE ANY ACTION AGAINST YOU FOR FILING A COMPLAINT.

- ***Right to Receive a Copy of this Notice*** – You may request a copy of our Notice at any time by using the contact information list at the end of the Notice. If you receive this Notice on our web site or by electronic mail (e-mail), you are also entitled to request a paper copy of the Notice.

Contact Information

If you have any questions about this Notice, our privacy practices related to your PHI or how to exercise your rights you can contact us in writing or by phone using the contact information listed below.

Care1st Health Plan Arizona
Attn: Privacy Official
1850 W Rio Salado Parkway Suite 211
Tempe, AZ 85281
1-866-560-4042 (TTY/TDD **711**)

Managed Care Terminology & Definitions

AHCCCS Complete Care Contractor: A contracted Managed Care Organization (also known as a health plan) that, except in limited circumstances, is responsible for the provision of both physical and behavioral health services to eligible Title XIX/XXI persons enrolled by the administration.

AHCCCS Complete Care-Regional Behavioral Health Agreement: An AHCCCS Complete Care (ACC) Contractor with expanded contractual responsibilities, as specified in CCE No. YH20-0002, for the provision of Non-Title XIX/XXI services for Title XIX/XXI and Non-Title XIX/XXI members and comprehensive Title XIX/XXI physical health and behavioral health services to eligible individuals with a Serious Mental Illness designation.

AHCCCS Eligibility Determination: The process of determining, through an application and required verification, whether an applicant meets the criteria for Title XIX/XXI funded services.

Anniversary Date: The anniversary date is 12 months from the date the member is enrolled with the Contractor and annually thereafter. In some cases, the anniversary date will change based on the last date the member changed Contractors or the last date the member was given an opportunity to change.

Appeal: The request for review of an adverse benefit determination.

Appeal Resolution: The written determination by health plan concerning an appeal.

Assessment: An analysis of a patient's needs for physical health services or behavioral health services to determine which services a health care institution shall provide to the patient as specified in A.A.C. R9-10-101.

Assessment – Behavioral Health: The ongoing collection and analysis of an individual's medical, psychological, psychiatric, and social conditions in order to initially determine if a health disorder exists, if there is a need for behavioral health services, and on an ongoing basis ensure that the individual's service plan is designed to meet the individual's (and family's) current needs and long-term goals.

Behavioral Health: Mental health and substance use collectively.

Copayment: A monetary amount that a member pays directly to a provider at the time a covered service is rendered as specified in A.A.C. R9-22-711.

Dental Home: The ongoing relationship between the dentist and the member, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. The dental home should be established no later than 12 months of age to help children and their families institute a lifetime of good oral health. A dental home addresses anticipatory guidance and preventive, acute, and comprehensive oral health care and includes referral to dental specialists when appropriate according to the American Academy of Pediatric Dentistry (AAPD).

Dental Provider: An individual licensed as specified in A.R.S. Title 32, Chapter 11, whose scope of practice allows the individual to: a. Independently engage in the practice of dentistry as specified in A.R.S. § 32-1202, 2. A dentist as specified in A.R.S. § 32-1201, 3. A dental therapist as specified in A.R.S. § 32-1201, 4. A dental hygienist as specified in A.R.S. § 32-1201, 5. An affiliated practice dental hygienist as specified in A.R.S. § 32-1201.

Emergency: Medical or behavioral health services provided for the treatment of an emergency medical condition. Refer to the term Emergency – Medical Condition.

Emergency Ambulance Services: Emergency ambulance services as specified in 9 A.A.C. 22, Article 2, 9 A.A.C. 25, and in 42 CFR 410.40 and 414.605.

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

1. Placing the patient's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
2. Serious impairment to bodily functions.
3. Serious dysfunction of any bodily organ or part as specified in 42 CFR 438.114(a), or
4. Serious physical harm to another individual (for behavioral health condition).

Emergency Transportation: Ground and air ambulance services that are medically necessary to manage an emergency physical or behavioral health condition and which provide transport to the nearest appropriate facility capable of treating the individual's condition. Emergency transportation is needed when due to a sudden onset of a physical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could be expected to result in:

1. Placing the member's health in serious jeopardy, or
2. Serious impairment of bodily functions, or
3. Serious dysfunction of any bodily organ or part, or
4. Serious physical harm to self or another individual.

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

- Above a limit
- Experimental
- Not medically needed

Grievance: A member's expression of dissatisfaction with any matter, other than an adverse benefit determination.

Habilitation: The process by which an individual is assisted to acquire and maintain those life skills that enable the individual to cope more effectively with personal and environmental demands and to raise the level of the individual's physical, mental, and social efficiency as specified in A.R.S. § 36-551 (18).

Health Insurance: Coverage of costs for healthcare services

Home Health Services: Nursing services, home health aide services, therapy services, and medical supplies, equipment, and appliances as specified in 42 CFR 440.70 when provided to a member at his place of residence and on his or her physician's orders, or beginning March 1, 2020, ordered by the member's nurse practitioner, physician assistant, or clinical nurse specialist, as a part of the plan of care and is reviewed by the practitioner annually as part of a written plan of care as specified in 42 CFR 440.70.

Homeless: An individual is considered homeless only when they reside in one of the places described below:

1. A place not meant for human habitation, such as cars, parks, sidewalks, abandoned buildings (on the street).
2. In an emergency shelter.
3. In transitional or supportive housing for homeless individuals who originally came from the streets or emergency shelters.
4. In any of the above places but is spending a short time (up to 30 consecutive days) in a hospital or other institution.
5. Is being evicted within a week from a private dwelling unit and no subsequent residence has been identified and lacks resources and support networks needed to obtain housing.
6. Is being discharged within a week from an institution, such as a mental health or substance abuse treatment facility or a jail/prison, in which the individual has been a resident for more than 30 consecutive days and no subsequent residence has been identified and the individual lacks the resources and support networks needed to obtain housing for example:
   a. An individual being discharged from prison after more than 30 days is eligible ONLY IF no subsequent residence has been identified and the individual does not have money, family, or friends to provide housing,
   b. Is fleeing a domestic violence housing situation and no subsequent residence has been identified and lacks the resources and support networks needed to obtain housing.

Hospice Services: Palliative and support care for members who are certified by a physician as being terminally ill and having six months or less to live.

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

Hospitalization: Admission to, or period of stay in, a health care institution that is licensed as a hospital as specified in A.A.C. R9-22-101.

KidsCare: Federal and State Children's Health Insurance Program (Title XXI – CHIP) administered by AHCCCS. The KidsCare program offers comprehensive medical, preventive, treatment services, and behavioral health care services statewide to eligible children under the age of 19, in households with income between 133 percent and 200 percent of the Federal Poverty Level (FPL).

In-Network Provider: A healthcare provider that has a contract with Care1st.

Managed Care: Systems that integrate the financing and delivery of health care services to covered individuals by means of arrangements with selected providers to furnish comprehensive services to members; establish explicit criteria for the selection of health care providers; have financial incentives for members to use providers and procedures associated with the plan; and have formal programs for quality, medical management, and the coordination of care.

Medical Equipment and Appliances: Item as specified in 42 CFR 440.70, that is not a prosthetic or orthotic; and

1. Is customarily used to serve a medical purpose, and is generally not useful to an individual in the absence of an illness, disability, or injury,
2. Can withstand repeated use, and
3. Can be reusable by others or removable.

Medical equipment and appliances may also be referred to as Durable Medical Equipment (DME).

Medically Necessary: A covered service provided by a physician or other licensed practitioner of the health arts within the scope of practice under State law to prevent disease, disability or other adverse conditions or their progression, or to prolong life as specified in A.A.C. R9-22-101.

Network: A list of doctors, other health care providers, and hospitals that a contractor contracts with directly, or employs through a subcontractor, to provide medical care to its members.

Non-Participating Provider: An individual or entity that provides services as specified in A.R.S. § 36-2901 who does not have a contract with Care1st.

Notice of Adverse Benefit Determination (NOA): The written notice provided to the affected member/Health Care Decision Maker (HCDM) which explains the Adverse Benefit Determination made by the Contractor or AHCCCS regarding the service authorization to deny, reduce, suspend, or terminate a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested as specified in 42 CFR 438.210(c), 42 CFR 438.404, and 42 CFR 438.400(b).

Out-of-Network Provider: An individual or entity that has a provider agreement with the AHCCCS Administration pursuant to A.R.S. § 36- 2904 which does not have a contract with a health plan. and which provides services specified in A.R.S. § 36-2901 et seq.

You may be responsible for the cost of care for out-of-network providers.

Physician Services: Healthcare services given by a licensed physician.

Premium: The amount an individual pays for health insurance every month. In addition to the premium, an individual usually has to pay other costs for their health care, including a deductible, copayments, and coinsurance.

Prescription Drugs: Prescription medications prescribed by an AHCCCS registered qualified practitioner as a pharmacy benefit, based on medical necessity, and in compliance with Federal and state law as specified in 42 U.S.C 1396r-8 and A.A.C. R9-22-209.

Primary Care: All health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/ gynecologist, pediatrician, or other licensed practitioner as authorized by the State Medicaid program, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them [42 CFR 438.2].

Primary Care Physician: A physician defined as an individual licensed as an allopathic or osteopathic physician as specified in A.R.S. Title 32, Chapter 13, or Chapter 17 and who otherwise meets the definition of Primary Care Provider (PCP).

Prior Authorization: A health plan process of authorizing, in advance, the delivery of covered services based on factors including but not limited to medical necessity, cost effectiveness, compliance with this Article and any applicable contract provisions. Prior Authorization is not a guarantee of payment as specified in A.A.C. R9-22-101.

Provider: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the State in which it delivers the services, as specified in 42 CFR 457.10 and 42 CFR 438.2.

Redetermination: A decision made by the AHCCCS/Division of Member and Provider Services (DMPS) regarding whether a member continues to meet the requirements as specified in A.A.C. R9-22-1305.

Referral: A verbal, written, telephonic, electronic, or in-person request for health services.

Rehabilitation: Physical, occupational, and speech therapies, and items to assist in improving or restoring an individual's functional level as specified in A.A.C. R9-22-101.

Service Plan: A complete written description of all covered health services and other informal supports which includes individualized goals, family support services, peer-and-recovery support, care coordination activities and strategies to assist the member in achieving an improved quality of life.

Skilled Service: A Competent Member, who is Medically Stable, or the member's legal guardian may employ an attendant care worker to also provide the following Skilled Services as specified in A.A.C. R9-28-508(G) including:

1. Bowel care, including: **a.** Suppositories, **b.** Enemas, **c.** Manual evacuation, and **d.** Digital stimulation.
2. Bladder catheterizations (non-indwelling) that do not require a sterile procedure.
3. Wound care (non-sterile).
4. Glucose monitoring.
5. Glucagon as directed by the health care provider.
6. Insulin by subcutaneous injection only if the member is not able to self-inject.
7. Permanent gastrostomy tube feeding, and
8. Additional services requested in writing with the approval of the Director

Special Assistance: The support provided to a member designated as Seriously Mentally Ill who is unable to articulate treatment preferences and/or participate effectively in the development of the Service Plan, Inpatient Treatment, and Discharge Plan (ITDP), grievance and/or appeal processes due to cognitive or intellectual impairment and/or medical condition.

Special Health Care Needs (SHCN): Serious and chronic physical, developmental, or behavioral conditions requiring medically necessary health and related services of a type or amount beyond that required by members generally; that lasts or is expected to last one year or longer and may require ongoing care not generally provided by a Primary Care Provider (PCP).

Specialist: A Board-eligible or certified physician who declares themselves as a specialist and practices a specific medical specialty. For the purposes of this definition, Board-eligible means a physician who meets all the requirements for certification but has not tested for or has not been issued certification.

Specialty Physician: A physician who is specially trained in a certain branch of medicine related to specific services or procedures, certain age categories of patients, certain body systems, or certain types of diseases.

Specialty Provider: Behavioral Health service that is not available in the Behavioral Health Home.

Standing Order: An AHCCCS Registered Prescriber's order that can be exercised by other health care workers for a member that meets the designated criteria by the prescribing provider.

Step Therapy: The practice of initiating drug therapy for a medical condition with the most cost-effective and safe drug and stepping up through a sequence of alternative drug therapies if the preceding treatment option fails.

Substance Abuse: An individual's misuse of alcohol or another drug or chemical as specified in A.A.C. R9-10-101, that:

1. Alters the individual's behavior or mental functioning.
2. Has the potential to cause the individual to be psychologically or physiologically dependent on alcohol or another drug or chemical, and
3. Impairs, reduces, or destroys the individual's social or economic functioning.

Substance Use Disorder: A range of conditions that vary in severity over time, from problematic, short-term use/abuse of substances to severe and chronic disorders requiring long-term and sustained treatment and recovery management.

Supportive Housing: Housing, as specified in 24 CFR Part 583, in conjunction with supportive services are provided for tenants if the housing is safe and sanitary and meets any applicable State and local housing codes and licensing requirements in the jurisdiction in which the housing is located and the requirements of this part; and the housing is transitional housing; safe haven; permanent housing for homeless individuals with disabilities; or is a part of, a particularly innovative project for, or alternative method of, meeting the immediate and long-term needs of homeless individuals and families.

Supportive Housing Services: Services to assist individuals or families to obtain and maintain housing in an independent community setting including the individual's own home or apartments and homes that are owned or leased by a subcontracted provider. These services may include:

1. Utility subsidies.
2. Relocation services to an individual or family for the purpose of securing and maintaining housing.
3. Employment services.
4. Budget and finance counseling, and
5. Eviction prevention.

Team Decision Making: A meeting process utilized to discuss a child's safety and where the child will live when an emergency removal of a child has occurred, or the removal of a child is being considered.

Teledentistry: The acquisition and transmission of all necessary subjective and objective diagnostic data through interactive audio, video, or data communications by an AHCCCS registered dental provider to a dentist at a distant site for triage, dental treatment planning, and referral.

Telehealth: Healthcare services delivered via asynchronous, audio-only, remote patient monitoring, teledentistry, or telemedicine.

Telemedicine: The practice of synchronous (real-time) health care delivery, diagnosis, consultation, and treatment and the transfer of medical data through interactive audio and video communications that occur in the physical presence of the member.

Transitional To Employment: Provides a member with individualized instruction, training, and support in the meaning, values, and demands of work to promote skill development for integrated and competitive employment.

Transitional Housing: Housing services that facilitate the movement of homeless individuals and families to permanent housing. A homeless individual may stay in transitional housing for a period not to exceed 24 months.

Treatment Plan: A written plan of services and therapeutic interventions based on a complete assessment of a member's developmental and health status, strengths and needs that are designed and periodically updated by the multi-specialty, interdisciplinary team.

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

Maternity Care Service Definitions

Certified Nurse Midwife (CNM): An individual certified by the American College of Nursing Midwives (ACNM) on the basis of a national certification examination and licensed to practice in Arizona by the State Board of Nursing. CNMs practice independent management of care for pregnant women and newborns, providing antepartum, intrapartum, postpartum, gynecological, and newborn care, within a health care system that provides for medical consultation, collaborative management, or referral.

Free Standing Birthing Centers: Out-of-hospital, outpatient obstetrical facilities, licensed by the Arizona Department of Health Services (ADHS) and certified by the Commission for the Accreditation of Free Standing Birthing Centers. These facilities are staffed by registered nurses and maternity care providers to assist with labor and delivery services and are equipped to manage uncomplicated, low-risk labor and delivery. These facilities shall be affiliated with, and in close proximity to, an acute care hospital for the management of complications, should they arise.

High-Risk Pregnancy: Refers to a condition in which the mother, fetus, or newborn is, or is anticipated to be, at increased risk for morbidity or mortality before or after delivery. High-risk is determined through the use of the Medical Insurance Company of Arizona (MICA) or American College of Obstetricians and Gynecologists (ACOG) standardized medical risk assessment tools.

Licensed Midwife (LM): An individual licensed by the Arizona Department of Health Services (ADHS) to provide maternity care as specified in A.R.S. Title 36, Chapter 6, Article 7, and A.A.C. R9-16 (This provider type does not include certified nurse midwives licensed by the Board of Nursing as a nurse practitioner in midwifery or physician assistants licensed by the Arizona Medical Board).

Maternity Care: Includes identification of pregnancy, prenatal care, labor/delivery services, and postpartum care.

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

Maternity Care Provider: The following are provider types who may provide maternity care when it is within their training and scope of practice:

1. Arizona licensed allopathic and/or osteopathic physicians who are obstetricians or general practice/family practice providers.
2. Physician Assistants.
3. Nurse Practitioners.
4. Certified Nurse Midwives, and
5. Licensed Midwives.

Practitioner: Refers to certified nurse practitioners in midwifery, physician assistant(s), and other nurse practitioners. Physician assistant(s) and nurse practitioners as specified in A.R.S. Title 32, Chapters 15 and 25, respectively.

Postpartum: The period that begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends. Quality measures used in maternity care quality improvement may utilize different criteria for the postpartum period.

Postpartum Care: Health care provided for a period that begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends.

Preconception Counseling: The provision of assistance and guidance aimed at identifying/reducing behavioral and social risks, through preventive and management interventions, in women of reproductive age who are capable of becoming pregnant, regardless of whether she is planning to conceive. This counseling focuses on the early detection and management of risk factors before pregnancy and includes efforts to influence behaviors that can affect a fetus prior to conception. The purpose of preconception counseling is to ensure that a woman is healthy prior to pregnancy. Preconception counseling is considered included in the well-woman preventative care visit and does not include genetic testing.

Prenatal Care: The provision of health services during pregnancy which is composed of three major components:

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

Discrimination is Against the Law

Care1st Health Plan Arizona (Care1st) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Care1st does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Care1st:

- Provides aids and services, at no cost, to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides language services, at no cost, to people whose primary language is not English, such as: qualified interpreters and information written in other languages

If you need these services, contact Member Services at:

Care1st: **1-866-560-4042** (TTY/TDD **711**), Monday — Friday, 8 a.m. to 5 p.m.

If you believe that Care1st failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the plan. You can file a grievance in person, by mail, fax, or email. Your grievance must be in writing and must be submitted within 180 days of the date that the person filing the grievance becomes aware of what is believed to be discrimination.

Submit your grievance to:

Care1st Health Plan

Attn: Grievance Coordinator

1850 W Rio Salado Parkway, Suite 211, Tempe, AZ 85281

Email via: **https://care1staz.com/az/aboutus/contact.asp**

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail at U.S. Department of Health and Human Services; 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201; or by phone: **1-800-368-1019**, **1-800-537-7697** (TTY).

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

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La Discriminación es un Delito

Care1st Health Plan Arizona (Care1st) cumple con las leyes federales vigentes sobre derechos civiles y no discrimina por raza, color, nacionalidad, origen, edad, discapacidad o sexo. Care1st no excluye a las personas ni las trata de manera diferente debido a su raza, color, nacionalidad, origen, edad, discapacidad o sexo.

Care1st:

- Proporciona asistencia y servicios gratuitos a personas con discapacidades para que se comuniquen de manera eficaz con nosotros, como los siguientes: intérpretes calificados de lengua de señas
- Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos)
- Proporciona servicios lingüísticos gratuitos a personas cuyo idioma principal no es el inglés, tales como intérpretes calificados e información escrita en otros idiomas

Si necesita estos servicios, llame a Servicios para Miembros al siguiente número:

Care1st: **1-866-560-4042** (TTY/TDD **711**), de lunes a viernes de 8 a.m. a 5 p.m.

Si considera que Care1st no le ha brindado estos servicios o lo ha discriminado de otra manera por motivos de raza, color, nacionalidad, origen, edad, discapacidad o sexo, puede presentar una queja ante el plan. Puede presentar una queja en persona, por correo, fax o correo electrónico. Su queja se debe realizar por escrito y se debe enviar en un plazo de 180 días a partir de la fecha en que la persona que presenta la queja toma conocimiento de lo que se considera como discriminación.

Envíe su queja a la siguiente dirección:

Care1st Health Plan

Attn: Grievance Coordinator

1850 W Rio Salado Parkway, Suite 211, Tempe, AZ 85281

Correo electrónico: **https://care1staz.com/az/aboutus/contact.asp**

También puede presentar una queja con respecto a los derechos civiles ante la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de EE. UU. de manera electrónica a través del Portal de Quejas de la Oficina de Derechos Civiles, disponible en **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf** o por correo postal a: U.S. Department of Health and Human Services; 200 Independence Avenue, SW; Room 509F, HHH Building; Washington D. C. 20201. Asimismo, puede presentar dicha queja por teléfono llamando al **1-800-368-1019**, **1-800-537-7697** (TTY).

Los formularios de queja están disponibles en **http://www.hhs.gov/ocr/office/file/index.html**.

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Attention: If you speak a language other than English, oral interpretation and written translation are available to you, at no cost, to understand the information provided. Call **1-866-560-4042** (TTY/TDD **711**).

Spanish	Si habla español, contamos con servicios de interpretación oral y traducción escrita, disponibles para usted de manera gratuita, para que pueda comprender la información. Llame al **1-866-560-4042** (TTY/TDD **711**).
Navajo	Dine k'ehji yanilti go ata' hane' ná hólo doo naaltsoos t'aa Dine k'ehji bee bik'e'ashchiigo nich'' adoolniilgo bee haz'a aldo ako dii t'a at'e t'aajiik'e kot'eegol nich'' sa'até. Koji holne **1-866-560-4042** (TTY/TDD **711**).
Chinese (Mandarin)	若您讲中文，我们会免费为您提供口译和笔译服务。请致电 **1-866-560-4042** (TTY/TDD **711**)。
Chinese (Cantonese)	我們為中文使用者免費提供口譯和筆譯。請致電 **1-866-560-4042** (TTY/TDD **711**)。
Vietnamese	Nếu quý vị nói tiếng Việt, quý vị được cung cấp dịch vụ phiên dịch và biên dịch, miễn phí, để quý vị hiểu được thông tin. Hãy gọi **1-866-560-4042** (TTY/TDD **711**).
Arabic	إذا كنت تتحدث لغة غير الإنكليزية، تتوفر لك ترجمة شفهية وترجمة كتابية مجانًا لكي تفهمَ المعلومات الموفَّرة. اتصل على الرقم **1-866-560-4042** (TTY/TDD **711**).
Tagalog	Kung ikaw ay nagsasalita ng Tagalog, may oral na interpretasyon at nakasulat na pagsasalin na maaari mong gamitin nang wala kang babayaran para maunawaan ang impormasyong ibinigay. Tumawag sa **1-866-560-4042** (TTY/TDD **711**).
Korean	한국어를 하실 경우, 제공된 정보의 이해를 위한 구두 통역 및 서면 번역 서비스를 무료로 제공해드릴 수 있습니다. **1-866-560-4042**(TTY/TDD **711**) 번으로 전화하십시오.
French	Si vous parlez français, vous disposez, sans frais, d'une interprétation orale et d'une traduction écrite pour pouvoir comprendre les informations fournies. Appelez le **1-866-560-4042** (TTY/TDD **711**).
German	Für alle, die Deutsch sprechen, stehen kostenlose Dolmetscher- und Übersetzungsservices zur Verfügung. Telefon: **1-866-560-4042** (TTY/TDD **711**).
Russian	Если вы говорите по-русски, вам бесплатно доступны услуги устного и письменного перевода предоставляемой информации. Звоните по телефону **1-866-560-4042** (TTY/TDD **711**).
Japanese	日本語を話される方は、 提供された情報を理解するための通訳（口頭）および翻訳（筆記）を無料でご利用いただけます。 電話番号 **1-866-560-4042**（TTY/TDD **711**）。
Persian (Farsi)	اگر به زبان انگلیسی صحبت نمیکنید، ترجمه شفاهی و کتبی به صورت رایگان برای شما در دسترس است تا بتوانید اطلاعات ارائه شده را متوجه شوید. با شماره **1-866-560-4042** (TTY/TDD **711**) تماس بگیرید.
Syriac	ܐܢ ܡܡܠܠܝܬܘܢ ܣܘܪܝܬ، ܡܨܐ ܡܢܘ ܠܗܘܐ ܐܡܝܢܐ ܥܠ ܬܪܓܡܐ ܫܡܫܘܬܐ ܕܬܘܠܡܝܕܐ ܡܓܢܢܐܝܬ **1-866-560-4042** (TTY/TDD **711**).
Serbo-Croatian	Ako govorite srpski ili hrvatski, usmeno i pismeno prevođenje vam je dostupno besplatno. Nazovite **1-866-560-4042** (TTY/TDD **711**).
Thai	หากคุณพูดภาษา ไทย เรามีบริการล่ามและแปลเอกสาร โดยไม่มี โทรศัพท์ **1-866-560-4042** (TTY/TDD **711**).

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Member Services:
1-866-560-4042 (TTY/TDD 711)

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Tempe, Arizona 85281

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