Member Handbook

October 1, 2023 to September 30, 2024

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

CARE1ST HEALTH PLAN ARIZONA, INC.

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, 2023

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. Go to findaprovider.care1staz.com to see the most current Provider Directory. The Provider Directory has information on our network providers, including:

- Names.
- Addresses.
- Telephone numbers.
- Whether they are accepting new patients.
- Professional qualifications.
- Language(s) spoken.
- Gender.
- Specialties.
- Board certification status.

To get a copy of the Provider 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 clinic.
- 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)
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, please call Member Services at **1-866-560-4042** (TTY/TDD: **711**) or go to **care1staz.com**.

Clinical Practice Guidelines

Care1st Health Plan uses clinical practice guidelines to help doctors make decisions about appropriate healthcare for specific clinical and behavioral healthcare conditions. Care1st Health Plan adopts practice guidelines that consider the needs of its members, which may include guidelines related to any applicable acute or chronic condition, behavioral health-related issue, and preventive or non-preventive guidelines. To get a copy of the clinical practice guidelines, call Member Services **1-866-560-4042** (TTY/TDD: **711**) for more information. Or go to **care1staz.com/providers/resources/practice-guidelines1.html**.

Urgent Care

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

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

If you are unable to reach your PCP, you can be seen at an urgent care clinic. You do not need an appointment to be seen at an urgent care clinic. However, you must use an urgent care clinic that is part of the Care1st network. For a list of urgent care clinics near you, go to **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).
- 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 19/21 eligible (i.e., not eligible for AHCCCS / not on Medicaid) or 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 need prior authorization.

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

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

- *Statewide 24-Hour Crisis Line:*
  - Call: **1-844-534-HOPE** (**4673**) (TTY/TDD: **711**)
  - Text: **4HOPE (44673)**
  - Chat: **crisis.solari-inc.org/start-a-chat**
- *Especially for Teens:*
  - Teen Life Line (call or text): **1-602-248-TEEN** (**8336**)
- *Especially for Veterans:*
  - Veterans Crisis Line: **1-800-273-8255** (**press 1**) or text **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, **1-928-527-1899**
  - ***West Yavapai Guidance Center:*** 3343 N Windsong Dr, Prescott Valley, AZ 86314, **1-928-445-5211**
  - ***Changepoint Integrated Care:*** 2500 E Show Low Lake Rd, Show Low, AZ 85901, **1-928-537-2951**
  - ***Mohave Mental Health Clinic:*** 3505 Western Ave, Suite A, Kingman, AZ 86409, **1-928-757-8111**
  - ***Southwest Behavioral Health:*** 1633 S Plaza Way, Flagstaff, AZ 86001, **1-877-756-4090**

National Suicide & Crisis Lifeline:

- Call or Text: **988**
- Chat: **988lifeline.org/talk-to-someone-now**

To get in touch with a nurse, call **1-866-560-4042** (TTY/TDD: **711**). Then choose the prompt for the 24-hour Nurse Advice Line.

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 get these services in a variety of ways:

- Call Member Services at **1-866-560-4042** (TTY/TDD: **711**).
- Talk to your PCP.
- Go to **findaprovider.care1staz.com** for a list of contracted behavioral health providers.
- Use 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), and the Substance Abuse Block Grant (SABG) Coronavirus Response and Relief Supplemental Appropriations Act (CRRSAA) Funding.

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 **azahcccs.gov/Members/BehavioralHealthServices/OpioidUseDisorderAndTreatment/Locating_Treatment.html**

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.

If you need any printed member materials, they can be requested 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. Go to **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).
- Accessible electronic formats.
- Other accessory material with taglines in the prevalent, non-English languages in Arizona.

Hearing Impaired

Care1st contracts with **Valley Center of the Deaf (VCD)** to provide licensed American Sign Language interpreters. Services can be arranged by calling Care1st Member Services. If you need sign language services, please call at least **seven business days** before your appointment.

Audiology services to evaluate hearing loss is a covered service. This includes augmentative and alternative communication devices (AAC) for both speech-generating and non-speech-generating equipment. For help finding a provider, contact your Care Manager or call Member Services at **1-866-560-4042** (TTY/TDD: **711**) for help.

Translation Services

Care1st contracts with **CyraCom International** to provide language interpretation services at any of your Care1st medical appointments at no cost to you. Services are arranged directly by your provider or practice using a unique PIN that CyraCom assigns to each provider or practice. Please have your provider or practice call **1-800-481-3293** to use this service. CyraCom's customer service is also available to help at **1-800-481-3289**.

Call Member Services if:

- You want to get information in another language or format.
- You need an interpreter.
- You need help with auxiliary aids.
- You would like to see the reading level of materials.

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 going to **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).

If the provider's office needs to call a member by telephone, they may do so via Arizona Relay Service. Providers may dial **711** for TTY/TDD users or go to **azrelay.org** to see other alternatives for members who do not use TTY/TDD. This is a state program, and there is no charge associated with this service.

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. Go to **care1staz.com** to find our Provider Directory. You may also call Member Services to get 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 you an ID card. This card identifies you as our member. It is important that you carry your ID card with you at all times. 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.
- Go to the hospital.
- Pick up a prescription.
- Get any other medical and behavioral healthcare.

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.

If you move out of Apache, Coconino, Mohave, Navajo, or Yavapai counties, or out of Arizona or 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, or Yavapai counties, it is still important to call your 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, a household member's change of job, etc., contact the eligibility source where you applied for AHCCCS:

- DES: **healthearizonaplus.gov** or **1-855-HEA-PLUS** (**1-855-432-7587**)
- KidsCare: **healthearizonaplus.gov** or **1-855-HEA-PLUS** (**1-855-432-7587**)
- SSI MAO: **healthearizonaplus.gov** or **1-602-417-5010** / **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** Fax: **1-888-507-3313** Mailing address: **801 E Jefferson St, MD 3900, Phoenix, AZ 85034**

Go to **azahcccs.gov/AHCCCS/Downloads/HowToUpdateYourMailingAddress.pdf** for more information.

Annual Enrollment Period — AHCCCS Complete Care (ACC) Only

Title 19/21 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 are a member who is eligible for Medicaid, you do not have an SMI designation, and you want to change your health plan before or after your anniversary date, you can do so either through the HEAplus system (healthearizonaplus.gov) or by contacting AHCCCS at 1-602 417-7100 or 1-800-334-5283. 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.
- 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.

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)
1-877-236-0375	**1-877-236-0375**

If you have a problem that needs to be addressed within 24 to 72 hours but is not life-threatening, you may be able to be seen at an urgent care clinic or at your PCP's office. Some examples of the difference between an urgent need and an emergency are listed below.

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

- 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: face drooping, 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 or insect 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 to 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 at **1-877-236-0375**.

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 clinic 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 your behavioral health provider.

For some physical health 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 a Serious Mental Illness (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 healthcare 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, 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 if 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 48)
    - 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 23)
14. Insulin pumps
15. Kidney dialysis

16. Limited dental services for members age 21 and over (see Adult Services page 42)
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 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.
- Nutritional screening, assessment, and therapy.
- Developmental surveillance with anticipatory guidance and screening.
- 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).
- The replacement and repair of eyeglasses without restriction to vision services.
- 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 **1-866-775-2192** to get the help you need.

Get connected with the right social services, including:

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

AHCCCS Excluded/Limited Benefits Table		
Benefit/Service	**Service Description**	**Service Excluded/Limited From Payment**
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.
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.
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 Oct. 1 through Sept. 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).

Accessing Non-Title 19/21 Services

AHCCCS covers Non-Title 19/21 behavioral health services within certain limits for Title 19/21 and Non-Title 19/21 members when medically necessary. These services may include auricular acupuncture, childcare (SUD only), traditional healing, supported housing, and room and board (when in a behavioral health residential facility setting).

Additionally, some services from the Regional Behavioral Health Authority are available to members who are not eligible for Medicaid (Non-Title 19/21). Grant- and state-funded programs include activities to:

- Prevent and treat substance use disorders and opioid use disorders.
- Provide services for HIV and tuberculosis.
- Provide mental health services to adults with Serious Mental Illness (SMI) and children with Serious Emotional Disturbance (SED).

These services are limited and provided based on whether or not funding is available.

Grant funds may be used for copayment coverage based on available funding and eligibility. Please refer to the *Copayments* section for information about copayments. These funds are provided by the following grants: State Substance Use Disorder Services (SUDS), Children's Behavioral Health Services Funds, (CBHSF), Arizona Emergency COVID-19 Project, Coronavirus Response and Relief Supplemental Appropriations Act (CRRSAA), Mental Health Block Grant (MHBG), State Opioid Response (SOR), and Substance Abuse Prevention and Treatment Block Grant (SABG).

You can find out more about these programs at **care1staz.com** or calling Member Services at **1-866-560-4042** (TTY/TDD: **711**).

Housing Services

Supportive housing services are available to Care1st members. These services help 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 a member's behavioral health provider.

The Continuum of Care (CoC) program works toward ending homelessness by funding efforts by nonprofit providers and state and local governments to quickly rehouse individuals and families while minimizing the trauma and dislocation caused by homelessness.

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 19/21 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.**	**housing.az.gov**
Balance of State Continuum of Care (CoC)	**Northern Arizona and Balance of State Coordinated Entry.**	**housing.az.gov/general-public/homeless-assistance**
Maricopa County Continuum of Care (CoC)	**Maricopa County Coordinated Entry.**	**azmag.gov/Programs/Homelessness**

Name	Who or How They Can Help	Website or Contact Information
Pima County Continuum of Care (CoC)	Pima County Coordinated Entry.	**tpch.net**
Housing Solutions of Northern Arizona	Transitional living, credit counseling, and affordable rentals.	**housingnaz.org**
Housing Authority of Flagstaff Arizona	Help for low-income families.	**flagstaff.az.gov/2342/HousingAuthority**
Mohave County Housing Authority	Housing help and Housing Choice Voucher.	**publichousing.com/details/mohavecounty**
Catholic Charities Community Services	Help with food, clothing, and shelter in Coconino and Mohave counties.	**catholiccharitiesaz.org**
Northern Arizona Council of Governments (NACOG)	Help with emergency rentals.	**nacog.org**
Navajo Nation in Flagstaff	General housing help.	**navajo-nsn.gov**
Western Arizona Council of Governments (WACOG)	Homeless prevention and utility help in Mohave, La Paz, and Yuma counties.	**wacog.com**
ABC Housing	Provides quality, affordable housing and supportive services for persons with behavioral health needs in Arizona.	**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.	**hominc.com**
Changepoint Integrated Health	**Navajo County** Show Low, Pinetop-Lakeside, Holbrook, and Winslow.	**mychangepoint.org**

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

Employment Services

Did You Know….?

- Working can be an important part of a person's recovery, as it gives structure and routine while boosting self-esteem and improving financial independence.
- Even if you are collecting public benefits, like Social Security, you may be able to make more money and still keep your medical benefits.
- For people with disabilities, vocational rehabilitation is an important resource to help you reach your job goals.

AHCCCS Employment Services

You may be able to get employment and rehabilitation services through your behavioral or integrated health home. This includes both pre- and post-employment services to help you get and keep a job. Some examples of the employment services you may be able to get include:

- Career / educational counseling.
- Benefits planning and education.
- Connection to vocational rehabilitation and/or community resources.
- Job skills training.
- Résumé preparation and job interview skills.
- Assistance in finding a job.
- Job support (job coaching).

To learn more about employment services and supports, or to get connected, ask within your behavioral or integrated health home, or contact Member Services at **1-866-560-4042** (TTY/TDD: **711**).

How to Connect to Employment Services

Most behavioral or integrated health homes have dedicated employment staff ready to help you. These staff members can connect you with employment services and supports that meet your needs. Staff will work with you to determine the best services based on your job goal.

Ask if your behavioral or integrated health home has dedicated employment staff. If so, set up a meeting to talk about your job goals. If your behavioral or integrated health home does not have dedicated employment staff, talk to your Care Manager or other staff to ask about getting connected.

Still need help? Call Care1st Member Services at **1-866-560-4042** (TTY/TDD: **711**). We can connect you to Care1st's Employment Administrator.

Other Employment Resources

Vocational Rehabilitation (VR)

VR is a program within the Arizona Department of Economic Security (ADES) designed to help eligible individuals who have disabilities prepare for, get, and keep a job.

You may be eligible for VR services if:

- You have a physical or mental disability.
- Your physical or mental disability results in a significant barrier to employment.
- You need VR services in order to prepare for, get, keep, or regain employment.
- You can benefit from VR services in terms of achieving an employment outcome.

Once you apply for the VR program and are determined eligible, you will work with a VR counselor to develop a plan for employment. This includes identifying a competitive employment goal. It will also address

any disability-related barriers to employment. Ask your behavioral or integrated health home about a referral to VR or contact a local VR office directly.

For more information and to locate the nearest VR office to you, visit **des.az.gov/services/employment/rehabilitation-services/vocational-rehabilitation-vr**.

ARIZONA@WORK

This statewide job center offers a wide array of workforce services to Arizona job seekers at no cost. Through ARIZONA@WORK, you can connect with local employers who have immediate job openings on Arizona's largest employment database, the Arizona Job Connection website.

ARIZONA@WORK can connect you to their partners for expert advice and guidance on everything from childcare, basic needs, vocational rehabilitation for job seekers with disabilities, and educational opportunities.

For more information and to locate the nearest ARIZONA@WORK office, visit **arizonaatwork.com**.

Benefits Planning & Education

There are a number of myths related to work and benefits. There are plenty of people living with disabilities who are on benefits and work — and are better off. Having a disability does not mean that you cannot work. Talk with your behavioral or integrated health home for more information on the following resources:

- **Arizona Disability Benefits 101 (DB101):** This no-cost, user-friendly online tool helps people work through the myths and confusion of Social Security benefits, healthcare, and employment. DB101 helps people make informed decisions about getting a job and how job income and benefits go together. Visit **az.db101.org** to use this tool.
- **ABILITY360:** Within ABILITY360 is a program called Benefits 2 Work Arizona's Work Incentives Planning & Assistance (B2W WIPA) that can help you understand how job income will affect your cash, medical, and other benefits. Call B2W WIPA at **1-602-443-0720** or **1-866-304-WORK (9675)**, or email **b2w@ability360.org** to see if you qualify for this service at no cost.

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.

- 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 rather 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: **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.
- Help you make an appointment.

Member Services staff is available Monday through Friday, from 8 a.m. to 5 p.m. 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.
- 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 call 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 can also get information about network providers who accommodate members with disabilities.

Call Member Services at **1-866-560-4042** (TTY/TDD: **711**) to have a copy of the Provider Directory mailed to you at no cost. You can also go to **care1staz.com** for the most current version of the directory.

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 Directory. Go to **care1staz.com** for the most up-to-date version of the directory. Then call Member Services at **1-866-560-4042** (TTY/TDD: **711**) 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.
- 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

For persons in the legal custody of the Department of Child Safety and adopted children in accordance with A.R.S. §8-512.01, behavioral health appointment standards are:

- Rapid response: No more than 72 hours after notification by DCS that a child has been or will be removed from their home.
- Rapid response initial assessment: Within seven calendar days after referral or request for behavioral health services.
- Rapid response initial appointment: No later than 21 calendar days after initial assessment.
- Rapid response subsequent services: No later than 21 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 Preventative Care

An annual well woman visit is a covered benefit for female members or members assigned female at birth. 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).
    - 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 PCP. There is no copayment or other charge for a well woman preventive care visit.

If you need help 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 **1-602-542-1219** or use the Clinic Locator at **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 healthcare resources, as well as to assist Medicaid recipients in effectively utilizing these resources.

EPSDT services provide comprehensive healthcare 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 healthcare, 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 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, family planning services and supplies, women's preventive care services, and maternity 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 3 and 5 years old, they may be able to get help before entering 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 provides 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 months
- 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 **1-602-542-1219**. Or use the Clinic Locator at **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.

Preventative and Well Care

Female members, or members assigned female at birth, have direct access to preventive and well care services from a PCP, OB/GYN, 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. Your maternity care provider must accept Care1st.

Maternity care includes identification of pregnancy, prenatal care, labor and delivery services, and postpartum care and services. It is important that you make and keep appointments with your provider during your pregnancy.

Your MCH coordinator will help you with questions or problems regarding your pregnancy. If you are new to Care1st or have recently transitioned to Care1st and are enrolled in your third trimester, you can keep getting your pregnancy care with your current AHCCCS-registered provider, regardless of whether that provider is contracted with Care1st. 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.

Family planning services and supplies are available to you. Your maternity care provider will give you information on family planning services and supplies. These might include birth control counseling and birth

spacing. Family planning supplies include birth control pills and shots, long-acting reversible contraceptives (LARC), diaphragms, 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 all 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 or prior authorization 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 woman 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 woman by:
    - **a.** Creating a serious physical or behavioral health problem for the pregnant woman,
    - **b.** Seriously impairing a bodily function of the pregnant woman,
    - **c.** Causing dysfunction of a bodily organ or part of the pregnant woman,
    - **d.** Exacerbating a health problem of the pregnant woman, or
    - **e.** Preventing the pregnant woman 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), COVID-19, 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, high blood pressure, cancer, sexually transmitted infections (STIs), 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

Envolve Dental provides dental benefits for Care1st members on behalf of Care1st. Envolve Dental takes care of:

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

If you have any questions, please call Envolve Dental at **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.

Dental service limitations as described above do not apply to American Indian / Alaska Native (AI/AN) members when they get dental services at an IHS/638 facility.

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 residence. A member may change their assigned dental home by calling Envolve Dental at the phone number listed 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 six 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. If you need to change or cancel an appointment, try calling 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 tool on the Care1st website lets you search for a pharmacy by name or ZIP code. Go to **findaprovider.care1staz.com**. You can also call Member Services for help finding a drugstore near you.

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, go to **care1staz.com/members/medicaid/benefits-services/pharmacy.html**.

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 call 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 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 and 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 a 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 members eligible for Medicare.
- Experimental medications.
- Drugs furnished solely for cosmetic purposes.
- Drugs prescribed for weight loss.

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**

Effective Jan. 1, 2024, the Care1st Specialty Pharmacy Network will include: AcariaHealth Pharmacy (preferred) and CVS Caremark Specialty Pharmacy for members on hemophilia drugs and/or in need of limited distribution drugs that are not available through AcariaHealth.

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 to get a four-day supply for you. From Oct. 1, 2023, through Dec. 31, 2023, call the Care1st PBM at 1-877-817-0474. After Jan. 1, 2024, have your pharmacist call 1-833-750-4339 to speak with a representative from the Care1st PBM team.

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 weekend, 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 a three-month time period.
- You use four or more providers in a three-month time period.
- You use four or more controlled medications and/or abuse-potential drugs in a three-month time period.

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.
- You have presented a forged or altered prescription to your pharmacy.
- 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 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 Copayments section.

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 (SUD). 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:

- By calling Member Services at **1-866-560-4042** (TTY/TDD: **711**).
- By talking to your PCP.
- By visiting **findaprovider.care1staz.com** for a list of contracted behavioral health providers.

You can also get services from a peer-run or family-run organization. Peer-run organizations are service providers owned, operated, and administrated by persons with lived experiences of mental health and/or substance use disorders. Family-run organizations are service providers owned, operated, and administrated by parents / persons with the lived experience of being the primary caregiver of a child or adult receiving mental health services. These organizations are based in the community and provide support services.

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

- One-on-one 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.
- Chances to meet new people.
- Personal development.
- Empowerment.
- Extended and/or weekend hours.

You can get these services by calling a peer-run 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-run 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-run 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).

Any individual from birth to 18 years of age can be evaluated for SED eligibility by a qualified clinician. SED eligibility determinations are made by Solari.

A person can request to be evaluated for SMI or SED services any time. If you would like more information on the referral process for getting a SED or an SMI designation you can do so by:

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

Your established provider or a contracted Care1st provider completes an evaluation and a SMI/SED assessment packet. A legal guardian / healthcare decision-maker may request an SMI/SED 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/SED determinations. Solari decides if the person is eligible. 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 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, special assistance, 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 1-844-534-4673 (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. **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 administration of a behavioral health delivery system that is consistent with AHCCCS values, principles, and goals:

1. Timely access to care,
2. Culturally competent and linguistically appropriate,
3. Promotion of evidence-based practices through innovation,
4. Expectation for continuous quality improvement,
5. Engagement of member and family members at all system levels, and
6. Collaboration with the greater community.

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 Department 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 to 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 behavior. Service plans shall also address the need for stability and promotion 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 individual where they are without judgment, with great patience and compassion.
2. **Individuals in recovery choose services and are included in program decisions and program development efforts**
   An individual in recovery has choice and a voice. Their self-determination in driving services, program decisions and program development are 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**
   An individual 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**
   An individual 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**
   An individual 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**
   An individual 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. **Individuals in recovery define their own success**
   An individual 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. Individuals 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**
   An individual in recovery can expect and deserves flexible, timely and responsive services that are accessible, available, reliable, accountable and sensitive to cultural values and mores. An individual in recovery is the source of their own strength and resiliency. Those who serve as supports and facilitators identify, explore and serve to optimize demonstrated strengths in the individual as tools for generating greater autonomy and effectiveness in life.

9. **Hope is the foundation for the journey towards recovery**
   An individual 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. An individual in recovery is held as boundless in potential and possibility.

Multispecialty Interdisciplinary Clinics (MSICS) & Children's Rehabilitative Services (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 **1-602-914-1520** **dmgcrs.org**	**Children's Clinics** Square & Compass Building 2600 N Wyatt Dr Tucson, AZ 85712 **1-520-324-5437** or **1-800-231-8261** **childrensclinics.org**
Children's Health Center - Flagstaff Med Ctr 1215 N Beaver St Flagstaff, AZ 86001 **1-928-773-2054** or **1-800-232-1018** **nahealth.com/childrens-health-center**	**Yuma Regional Medical Center (CRS)** 2851 S Avenue B, Bldg. 25 Yuma, AZ 85364 **1-928-336-2777** **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.

What is CRS?

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 MSICs. 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.
- 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. The CRS application can be found at azahcccs.gov/PlansProviders/Downloads/CRSApplicationEnglish.pdf. To apply for a CRS designation, please send us:

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

You can send us your application by:

Mail: AHCCCS-CRS Unit 801 E Jefferson St MD 3500 Phoenix, AZ 85034
Fax: 1-602-252-5286
E-mail: dmscrs@azahcccs.gov

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 behavioral 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 go to **care1staz.com/members/medicaid/resources/oifa.html** or email **OIFA@care1staz.com**.

Prior Authorization Requests for Services and Medications

Some services must be reviewed and approved (prior authorization) by Care1st. Some examples are MRIs, pain management, and inpatient procedures or 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.

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.

Prior authorization decisions are based only on appropriateness of care and service, and existence of coverage. Care1st does not specifically reward practitioners or other individuals for issuing coverage denials. 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.

Freedom of Choice 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

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 they are 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, call 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.

Members are exempt from Medicaid copayments as applicable.

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 pays its share.

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 information about both Care1st and any other health insurance you may have.

CRS members under 21 years of age with private insurance or Medicare may use their private insurance or Medicare provider networks to get 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 for by Medicare Part D or 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 part of both your Medicare HMO’s provider network 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). QMBs 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 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 or 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.

Complaints: How to File a Complaint If I Am Unhappy

If you are dissatisfied with your services or disagree with a decision made about your services, you always have the right to file a complaint (grievance) regarding any covered service provided by Care1st. Title 19/21 AHCCCS-eligible members, members determined to have a Serious Mental Illness, and members who are not enrolled as a person with Serious Mental Illness and are Non-Title 19/21 eligible have the right to file a complaint (grievance), and we are here to support you.

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 our service to you. 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** (TTY/TDD: **711**). You may also put your grievance in writing and mail it to:

Care1st Health Plan Arizona
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 Benefit Determination letter sent to you. You may have to pay the cost of services provided while the appeal or State Fair Hearing is pending.

Grievances (Complaints For Title 19/21 AHCCCS 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 our service to you. 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** (TTY/TDD: **711**). You may also put your grievance in writing and mail it to:

Care1st Health Plan Arizona
Attn: Member Services
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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 Title 19/21 AHCCCS 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 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.
- 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 Arizona
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 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 (AOR) form for you to sign and return within 30 days of the date the appeal was filed. We will work on your appeal once we get the AOR. If you do not sign and return the AOR form, the appeal will be denied for lack of 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 can help you file an appeal or request a hearing. Assistance includes use of a toll-free number, i.e., **1-866-560-4042** (TTY/TDD: **711**). Members can also 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 with the Notice of Adverse Determination letter you got.

Can a Health Care Decision Maker Submit Concerns on My Behalf?

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.

How to file a complaint regarding crisis 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 at **1-866-560-4042** (TTY/TDD: **711**).

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** (TTY/TDD: **711**). You may also put your grievance in writing and mail it to:

Care1st Health Plan Arizona
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 with the Notice of Adverse Determination letter you got. SMI members will not be charged for behavioral health services they get 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.

Grievances concerning physical abuse, sexual abuse, or a person's death are investigated by AHCCCS. To file an oral or written grievance concerning physical abuse, sexual abuse, or a person's death, please write to or call:

AHCCCS Office of Grievance and Appeals
801 E. Jefferson Street, Mail Drop 6200
Phoenix, AZ 85034
1-602-364-4575

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 Arizona
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 Arizona
Attn: Appeals Department
1850 W Rio Salado Parkway
Suite 211
Tempe, AZ 85281

You may also 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 (AOR) form for you to sign and return within 30 days of the date the appeal was filed. We will work on your appeal once we get the AOR. If you do not 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 can help you file an appeal or request a hearing. Assistance includes use of a toll-free number, i.e., **1-866-560-4042** (TTY/TDD: **711**). Members can also 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 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 Preadmission Screening and Resident Review (PASRR) determination which adversely affects the person.
- Decisions regarding the individual's eligibility for behavioral health services.

- The sufficiency or appropriateness of an assessment.
- The long-term view, service goals, objectives, or timelines stated in the Individual Service Plan (ISP) or Inpatient Treatment and Discharge Plan (ITDP).
- The recommended services identified in the assessment report, ISP, or ITDP.
- The actual services to be provided, as described in the ISP, plan for interim services, or ITDP.
- Access to or prompt provision of services.
- The findings of the clinical team with regard to the person's competency, capacity to make decisions, need for guardianship, or other protective services or need for Special Assistance.
- The denial of a request for a review of, the outcome of, a modification to or failure to modify, or termination of an ISP, ITDP, or portion of an ISP or ITDP.
- The application of the procedures and timeframes for developing the ISP or ITDP.
- The implementation of the ISP or ITDP.
- Decision to provide service planning, including the provision of assessment or case management services, to a person who is refusing such services, or a decision not to provide such services to the person.
- Decisions about a person's fee assessment or the denial of a request for a waiver of fees.
- Denial of a payment of a claim.
- Failure of the RBHA or AHCCCS to act within the established time frames regarding an appeal.

Solari is the statewide provider that performs 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 at:

Solari, Inc.
1275 W Washington St
Suite 210
Tempe, AZ 85281

If you file an appeal, you will get written notice within five business days of Care1st receiving the appeal. For an expedited appeal, you will get written notice that we got your appeal within one business day of receipt.

Please note: 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 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. For normal appeals, you will have an informal conference with Care1st within seven business days of filing the appeal. For expedited appeals, the informal conference must occur within two 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 two 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 two 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, you may not have to pay Care1st for services you got during the appeal process.

Grievances (Complaints) — For Non-Title 19/21 Non 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** (TTY/TDD: **711**). You may also put your grievance in writing and mail it to:

Care1st Health Plan Arizona
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 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 Non-Title 19/21 Non 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.
- 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 Arizona
Attn: Appeals Department
1850 W Rio Salado Parkway
Suite 211
Tempe, AZ 85281

You may also 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 (AOR) form for you to sign and return within 30 days of the date the appeal was filed. We will work on your appeal once we get the AOR. If you do not 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 can help you file an appeal or request a hearing. Assistance includes use of a toll-free number, i.e., **1-866-560-4042** (TTY/TDD: **711**). Members can also 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 with the Notice of Adverse Determination letter you got.

Opting Out- Changing Your Physical Health Services Plan for Members with SMI

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 for the member under one of the following conditions:

1. The network does not allow choice from at least two PCPs, or it does not have a needed specialty provider,
2. The current treating physician says there is a need to continue a course of treatment,
3. There is evidence of harm or unfair treatment.

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

Before you are moved to another AHCCCS healthcare plan, Care1st will try to resolve your concerns. If Care1st is not able to resolve your concerns, you or your representative may apply for a change in your health plan by calling Member Services at **1-866-560-4042** (TTY/TDD: **711**).

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

Care1st's review process will follow these steps:

- Care1st will confirm that you are enrolled in the integrated plan.
- Care1st Member Services will record your claims of actual harm, possible discrimination, or unfair treatment caused by enrollment in the integrated health plan.
- Care1st Member Services will complete the "Transfer of a SMI member enrolled in an RBHA to an AHCCCS Acute Care Contractor" form and include any evidence that you or your representative provide.

You will get the approval or denial in writing within 10 days of your request. If your request is approved, Care1st will work with your new AHCCCS healthcare plan to ensure there are no interruptions in your care. If your request is denied, you will get the reasons for the denial and you will be informed of your right to make an appeal.

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.

Care1st complies with all applicable civil rights laws and does not discriminate, exclude, or treat people differently on the basis of race, color, creed, national origin, age, disability, or sex.

Member Rights

As a Care1st member you have certain rights.

You have a right to:

1. Be treated fairly regardless of race, ethnicity, national origin, religion, gender, age, creed, behavioral health condition (intellectual) or physical disability, sexual preference, genetic information, or ability to pay.
2. To get information on available treatment options and alternative, accordingly and appropriate to your condition(s) and ability to understand the information.
3. File a complaint or an appeal about the managed care organization or network providers. Complaints and appeals can be filed with Care1st or AHCCCS.
4. Get information on the structure and operation of Care1st or its subcontractors.
5. 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.
6. 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.

7. Confidentiality and confidentiality limitations. See Notice of Privacy Practices for details.
8. To help arrange and pay for your care, there are times when your information is shared without first getting your written permission. These times could include the sharing of information with:
   - Physicians and other agencies providing health, social, or welfare services.
   - Your medical primary care provider.
   - Certain state agencies and schools following the law and involved in your care and treatment as needed.
   - Members of the clinical team in your care.
9. 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 go to **care1staz.com**. See Notice of Privacy Practices for details.
10. 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.
11. Discuss treatment options, regardless of cost or benefit coverage, presented in a manner appropriate to your condition and ability to understand the information.
12. Get information about formulating Advance Directives.
13. Ask for a copy of your medical records annually at no cost to you.*
14. Inspect your medical records at no cost to you.
15. Get a reply within 30 days to your request for a copy of your records.**
16. Ask that your medical records be updated or corrected.
17. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
18. Get information on beneficiary and plan information, the organization, services, practitioners and providers, and member rights and responsibilities.
19. Be treated with respect and with due consideration for your dignity and privacy.
20. Participate in decisions regarding your healthcare, refuse any medical treatments, and to be told what will happen if you do not get treatment.

21. Be given information about Care1st, including their qualifications and the languages other than English that they speak.
22. Use any hospital or other setting for emergency care.
23. Have your medical records and any information about your healthcare be private and confidential.
24. Choose your PCP from Care1st's list of PCPs. You also have the right to change PCPs if you wish to do so.
25. 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.
26. 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.
27. Get a summary of Care1st's member survey results.
28. Be told in writing of any changes to your services.
29. 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.
30. Get a copy of member rights and responsibilities and the right to make recommendations regarding Care1st rights and responsibilities policy.
31. 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 with the Notice of Adverse Determination letter you got. (Outside Maricopa County call **1-800-962-6690**.)
32. Decide who you want to be at your treatments and exams.
33. Tell Care1st about any problems, complaints, or grievances you have with your healthcare services, your providers, or Care1st.
34. 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.
35. 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; or 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. 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 that individual 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 that individual 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 at **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 get 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

Are you thinking about quitting tobacco use? ASHLine is the Arizona Smokers' Helpline that provides low or no cost help to people who want to quit tobacco and other nicotine products.

The ASHLine provides services to help people at all stages of quitting tobacco use. This includes those who are ready to quit, thinking about quitting, or who have quit and want help staying tobacco-free. It also provides information on the quitting process for family and friends who would like to learn more about the quit process.

ASHLine quit coaching and quit kits are available to AHCCCS members and Arizona residents who are underinsured, uninsured, or who are pregnant.

You can get help:

- By calling **1-800-556-6222**.
- At **azdhs.gov/ashline/** or **azdhs.gov/prevention/tobacco-chronic-disease/tobacco-free-az/index.php**
- Finding community support groups at **nicotine-anonymous.org**.

Care1st covers many products to help you quit. These include prescription drugs and over-the-counter (OTC) items. You must call your PCP for any of these products, including OTCs. Your PCP will decide which one would be best for you.

If you are under 18 years old, your doctor will need to get prior authorization (PA) for the drug you need. Your doctor will take care of this for you. Your plan covers up to a 12-week supply in a six-month time period. The six-month time period starts the date that you first get your drug from the pharmacy.

Community Resource List

There are local and national organizations that provide services and programs that can help you. Please go to **care1staz.com** for more information.

Alzheimer's Association

The Alzheimer's Association provides education and resources to those affected by Alzheimer's disease.

alz.org

1-800-272-3900

American Academy of Pediatrics (AAP)

The American Academy of Pediatrics (AAP) is a professional association made up of pediatricians and pediatric medical and surgical specialists. AAP promotes optimal physical, mental, and social health for infants, children, adolescents, and young adults.

aap.org

1-800-433-9016

American Diabetes Association

The American Diabetes Association's mission is to prevent and cure diabetes and to improve the lives of all people affected by diabetes.

diabetes.org

1-800-342-2383

American Lung Association

The American Lung Association's mission is to save lives by improving lung health and preventing lung disease through education, advocacy, and research.

lung.org

1-800-586-4872

Area Agency on Aging

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

aaaphx.org
nacog.org
wacog.com/area-agency-on-aging
pgcsc.org

Maricopa: **1-602-264-4357** or **1-888-783-7500**
Apache, Coconino, Navajo, and Yavapai: **1-877-521-3500**
Mohave: **1-800-782-1886 |** Gila and Pinal: **1-800-293-9393**

ARIZONA@WORK

ARIZONA@WORK is the statewide workforce development network that helps employers of all sizes and types recruit, develop, and retain the best employees for their needs. For job seekers in state, ARIZONA@WORK offers services and resources to those seeking employment opportunities.

arizonaatwork.com

Arizona Center for Disability Law (ACDL)

The Arizona Center for Disability Law (ACDL) is a not-for-profit public interest law firm dedicated to protecting the rights of individuals with physical, mental, psychiatric, sensory, and cognitive disabilities.

azdisabilitylaw.org

1-800-927-2260

Arizona Coalition Against Sexual and Domestic Violence (ACESDV)

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

acesdv.org

1-800-782-6400

Arizona Department of Economic Security Aging and Disability Resource Center

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

azlinks.gov

Arizona Department of Health Services (ADHS)

ADHS was established to protect the physical and mental health of Arizona citizens and to promote the highest standards for licensed healthcare institutions, emergency services, and care facilities for adults and children.

azdhs.gov

1-602-542-1025

Arizona Disability Benefits 101

DB101 helps people with disabilities and service providers understand the connections between work and benefits. DB101 will help you make informed choices and show you how you can make work part of your plan.

az.db101.org

1-866-304-WORK (9675)

ADHS Office for Children and Youth with Special Needs (OCSHCN)

ADHS programs and resources for children and youth with special healthcare needs focus on:

- Improving systems of care.
- Providing information and referrals to families.
- Providing training to families and professionals on best practices related to medical home, cultural competence, transition to adulthood, and family and youth involvement.
- Telemedicine to provide services in remote areas of the state.

azdhs.gov/prevention/womens-childrens-health/cyshcn/index.php

1-602-542-1860

ADHS Pregnancy and Breastfeeding Hotline

The Arizona Department of Health Services Pregnancy and Breastfeeding Hotline offers information about pregnancy test sites, low-cost providers, breastfeeding support, vitamins with folic acid, and TEXT4BABY resources.

azdhs.gov/prevention/nutrition-physical-activity/breastfeeding/index.php

1-800-833-4642

Arizona Early Intervention Program (AzEIP)

The Arizona Early Intervention Program (AzEIP, pronounced Ay-zip), helps families of children with disabilities or developmental delays from birth to age 3. AzEIP provides support and can work with children's natural ability to learn.

des.az.gov/azeip

1-602-532-9960

Affirm

Affirm serves people in Arizona, especially youth, the underinsured and uninsured, low-wage earners, indigenous communities, and other groups who have been systematically excluded from receiving care. Affirming the dignity of the people we serve is crucial to Affirm's approach. Affirm coordinates sexual and reproductive healthcare services, connects clients to caring providers, and offers inclusive health education.

affirmaz.org

1-602-258-5777

Arizona Health Care Cost Containment System (AHCCCS)

Arizona Health Care Cost Containment System (AHCCCS) is Arizona's Medicaid agency that offers healthcare programs to serve Arizona residents. Individuals must meet certain income and other requirements to obtain services.

azahcccs.gov

1-602-417-7000 or **1-800-962-6690**

Arizona Immunization Program

Information and resources for adults, adolescents, and children, including clinic locations and recommended vaccination schedules.

azdhs.gov/preparedness/epidemiology-disease-control/immunization/index.php

1-602-542-1025

Arizona Smokers' Helpline (ASHLine)

A no-cost phone and online resource available 24 hours a day, seven days a week to help you quit tobacco.

azdhs.gov/ashline
azdhs.gov/prevention/tobacco-chronic-disease/tobacco-free-az/index.php

1-800-556-6222

Arizona Suicide Prevention Coalition

Arizona Suicide Prevention Coalition works to reduce suicidal acts in Arizona. Their mission is to change those conditions that result in suicidal acts in Arizona through awareness, intervention, and action.

azspc.org

Arizona Department of Economic Security (DES), Nutrition, Cash, and Medical Assistance Benefits

DES is state agency that helps Arizonans reach their potential through temporary assistance for those in need and care for the vulnerable.

des.az.gov/services/basic-needs/food-assistance/contact-us

1-855-777-8590

Arizona Youth Partnership Starting Out Right Program

Starting Out Right provides no-cost pregnancy and parenting education to those 21 and under.

azyp.org/program/starting-out-right

1-877-882-2881

AZ Links

azdaars.getcare.com/consumer

Childhelp National Child Abuse Hotline

Childhelp exists to meet the physical, emotional, educational, and spiritual needs of abused, neglected, and at-risk children.

childhelp.org

1-800-4-A-CHILD or **1-800-422-4453**

Community Information and Referral

Community Information and Referral is a call center that can help you find many community services, such as food banks, clothes, shelters, help to pay rent and utilities, healthcare, pregnancy health, help when you or someone else is in trouble, support groups, counseling, help with drug or alcohol problems, financial help, job training, transportation, education programs, adult daycare, meals on wheels, respite care, home healthcare, transportation, homemaker services, childcare, after-school programs, family help, summer camps and play programs, counseling, help with learning, and protective services.

211arizona.org

211

Dental — Reduced Fee and Community Dental Clinics in Arizona

A list of clinics that provide dental health services at low or no cost to people without health insurance. See the list at the site below for locations and phone numbers:

azdhs.com/documents/prevention/womens-childrens-health/oral-health/reduced-fee-dental-clinics.pdf

Dump the Drugs AZ

App that provides information on where to dispose of unused or unwanted medications and prescription drugs. Locate and get directions to the nearest safe disposal site.

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

Federal Health Insurance Marketplace

HealthCare.gov is a website run by the United States government. It is sometimes called the "healthcare exchange" or "health insurance marketplace." You can compare health insurance plans for coverage and affordability, enroll in or change health insurance plans, find out about tax credits for private insurance of health programs like Medicaid or the Children's Health Insurance Program, and get answers to questions about healthcare insurance.

healthcare.gov

1-800-318-2596

Fussy Baby / Birth To Five Helpline

The Birth to Five Helpline is a service open to all Arizona families with young children looking for the latest child development information from experts in the field.

swhd.org/programs/health-and-development/fussy-baby

1-877-705-KIDS or **1-877-705 5437**

Arizona Head Start/Early Headstart

HEAD START provides early education for 3-5 year-old children, parent involvement and family support, and comprehensive health and nutrition education for children.

EARLY HEAD START serves women who are pregnant and children Birth to 3 years old.

azheadstart.org

Maricopa: **1-602-338-0449**
Apache, Coconino, Navajo, and Yavapai: **1-928-774-9504**
Gila and Pinal: **1-888-723-7321**
Mohave: **1-928-782-1886**

Vaccines for Children (VCF)

The Vaccines for Children (VCF) program is a federally funded program that provides vaccines at no cost to children who might not otherwise be vaccinated because of an inability to afford vaccines.

1-602-364-3630

azdhs.gov/preparedness/epidemiology-disease-control/immunization/index.php#vaccines-children-home

The Arizona Immunization Program

The Arizona Immunization Program provides information and resources for adults, adolescents, and children, including clinic locations and recommended vaccine schedules.

1-602-364-3630

azdhs.gov/preparedness/epidemiology-disease-control/immunization/index.php#get-vaccinated

Health-e-Arizona Plus

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

healthearizonaplus.gov

1-855-432-7587

Mentally Ill Kids in Distress (MIKID)

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

mikid.org

Gila, Maricopa, and Pinal: **1-602-253-1240**
Apache, Coconino, Mohave, Navajo, and Yavapai: **1-928-775-4448**

National Alliance on Mental Illness (NAMI) Arizona

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

namiarizona.org

1-800-950-6264

National Suicide Prevention Lifeline

National Suicide Prevention Hotline is committed to improving crisis services and suicide prevention by empowering individuals, using professional best practices, and building awareness.

988lifeline.org

988

Opioid Assistance & Referral

The Opioid Assistance and Referral Line offers patients, providers, and family members opioid information, resources, and referrals 24 hours a day, seven days a week.

azdhs.gov/oarline

1-888-688-4222

Poison Control

The Arizona Poison and Drug Information Center provides expert medical knowledge to Arizonans when they have a poison emergency.

azpoison.com

1-800-222-1222

Postpartum Support International

Postpartum Support International is dedicated to helping families suffering from postpartum depression, anxiety, and distress.

postpartum.net

1-800-944-4773 or text:
English: **1-800-944-4773**
Español: **971-203-7773**

Power Me A2Z

Power Me A2Z provides vitamins to people in Arizona.

powermea2z.org

Raising Special Kids

Raising Special Kids exists to improve the lives of children with a full range of disabilities, from birth to age 26. Raising Special Kids provides support, training, information, and assistance so families can become effective advocates for their children.

raisingspecialkids.org

1-602-242-4366 or **1-800-237-3007**

Sliding Fee Schedule Clinics (no cost or low cost)

Clinics in Arizona that provide free or low-cost services to people who don't have health insurance.

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

1-602-542-1219

St. Vincent de Paul Dental Clinics (Maricopa County)

Vincent de Paul's charity dental clinic provides treatment and preventive care to children and adults without insurance and inspires thousands to healthier hygiene.

stvincentdepaul.net

1-602-261-6868

Strong Families AZ

Strong Families AZ is a network of home-visitation programs that help families raise children who are ready to succeed in school and life. To find a program near you, go to the below website and enter your ZIP code.

strongfamiliesaz.com

Teen Life Line

Teen Lifeline is a safe, confidential crisis service where teens help teens make healthy decisions through 24-hour peer counseling and suicide prevention services.

teenlifeline.org

1-602-248-8336 (TEEN) or **1-800-248-8336** (TEEN)

Tobacco Free Arizona

Tobacco Free Arizona is a program to help Arizonans know the risks of tobacco use and provide resources for quitting.

azdhs.gov/prevention/tobacco-chronic-disease/tobacco-free-az/index.php

1-800-556-6222

Vocational Rehabilitation

The Vocational Rehabilitation program offers employment services to people with disabilities to demonstrate that vocational rehabilitation is an employment program. Their goal is to help participants enter the workforce or keep a job.

des.az.gov/services/employment/rehabilitation-services/vocational-rehabilitation

1-800-563-1221

Women, Infants, and Children (WIC) Arizona

Women, Infants, and Children (WIC) Arizona provides nutrition education and breastfeeding support services, supplemental nutritious foods, and referrals to health and social services. WIC serves pregnant, breastfeeding, and postpartum individuals; infants; and children under the age of 5 who are determined to be at nutritional risk. The WIC Program is funded by the United States Department of Agriculture.

azdhs.gov/prevention/azwic

1-800-252-5942

Low Cost/Sliding Scale Healthcare Providers

If you become ineligible for Medicaid and are not able to get other health insurance, you can look for clinics that give primary, mental, and dental health services at low or no cost to people without health insurance. Go to **azdhs.gov/prevention/health-systems-development/sliding-fee-schedule/index.php** to find a clinic near you.

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 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.

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

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

For more information, call Member Services.

Advance Directives — Decisions About Your Healthcare

Reference: Arizona Secretary of State — **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 **1-800-458-5842** or go to **azsos.gov**. You can find the forms you will need to complete your advance directive on the 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 **azsos.gov** or you can call **1-800-458-5842**.

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 healthcare directive?
A healthcare 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 healthcare (medical) power of attorney?
A healthcare (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 healthcare (medical) power of attorney can be part of another advance directive form, such as a healthcare directive or living will, or may be a separate document. The person you appoint to make decisions for you when you cannot make those decisions on your own called an "agent."

5 Does an agent appointed in a healthcare (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 healthcare (medical) power of attorney?
None. Your healthcare (medical) power of attorney is not a medically trained person. The person you appoint as your healthcare (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 healthcare (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 healthcare (medical) power of attorney become effective?
An advance directive, including a healthcare (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 healthcare (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:

- **a.** A guardian.
- **b.** A healthcare (medical) power of attorney.
- **c.** A surrogate.
- **d.** The patient's spouse, unless legally separated.
- **e.** An adult child of the patient or a majority of adult children.
- **f.** A parent of the patient.
- **g.** The patient's domestic partner if the patient is unmarried.
- **h.** The sibling of the patient.
- **i.** A close friend of the patient.
- **j.** 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 healthcare (medical) power of attorney?
In Arizona, if you do not appoint a healthcare (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 healthcare (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" or "orange form."

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 healthcare (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 healthcare (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 healthcare power of attorney?**
A mental healthcare 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 healthcare power of attorney?**
Only a Mental Healthcare 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
Phone: 1-602-417-7000 (Outside Maricopa County: 1-800-962-6690)
E-mail: MedicalManagement@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 go to **azlinks.gov** or **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 ages 60 and older, adults ages 18 and older with HIV/AIDS, adults ages 18 and older 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 at **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 can be reached at **1-602-279-2980**, Monday through Friday, from 8:30 a.m. to 5 p.m. or at **acesdv.org**.

Arizona Peer and Family Coalition, Northern Arizona Peer and Family Coalition

The mission of the Arizona Peer and Family Coalition is to advocate for behavioral healthcare through connecting, promoting, and developing leadership by peers, family members, and allies statewide. Learn more at **azpeerandfamily.online**.

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 **1-602-576-4828** or **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 **nami.org**.

National Domestic Violence Hotline

The National Domestic Violence Hotline can help victims and survivors of domestic violence. The National Domestic Violence Hotline can be reached at **1-800-799-7233** or **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 and can be accessed by calling **1-800-421-2124**.

Special Assistance Information for Members with SMI

Special Assistance is a unique clinical designation that provides support to members with an SMI determination who are unable to communicate and/or participate during treatment planning, discharge planning, or the grievance and appeal process.

When a health home clinical team or other qualified assessor determines that a member meets Special Assistance criteria, they notify the Office of Human Rights. The Office of Human Rights will assign an individual to meet the member's Special Assistance needs and to advocate on behalf of the member during treatment and/or discharge planning and during the grievance and appeals process. Care1st works in collaboration with the AHCCCS Office of Human Rights to ensure members meeting Special Assistance criteria are appropriately identified. You can reach the Care1st Individual and Family Affairs (OIFA) team by calling Member Services at **1-866-560-4042**, (TTY/TDD: **711**) and asking to speak to someone from the OIFA Team about Special Assistance.

You can contact the office of Human Rights at **1-800-421-2124**.

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

Words/Phrases

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

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

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

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

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

Emergency Medical Transportation: See EMERGENCY AMBULANCE SERVICES

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

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

Emergency Services: Services to treat an emergency condition.

Excluded Services: See EXCLUDED

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

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

Words/Phrases

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

Habilitation Services and Devices: See HABILITATION

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

Health Insurance: Coverage of costs for health care services.

Home Health Care: See HOME HEALTH SERVICES

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

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

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

Hospitalization: Being admitted to or staying in a hospital.

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

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

Non-Participating Provider: See OUT OF NETWORK PROVIDER

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

Words/Phrases

Participating Provider: See IN-NETWORK PROVIDER

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

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

Plan: See SERVICE PLAN

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

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

Preauthorization: See PRIOR AUTHORIZATION

Prior Authorization: Approval from a health plan that may be required before you get a service. This is not a promise that the health plan will cover the cost of the service.

Premium: The monthly amount that a member pays for health insurance. A member may have other costs for care including a deductible, copayments, and coinsurance.

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

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

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

Words/Phrases

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

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

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

Rehabilitation Services and Devices: See REHABILITATION

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

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

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

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

Maternity Care Service Definitions

Words/Phrases

Certified Nurse Midwife (CNM): A provider that has been certified by the American College of Nursing Midwives (ACNM). This is done by the provider passing a national exam and having a license to practice in Arizona. The license is granted by the Arizona Board of Nursing. CNMs provide medical care for pregnant women and newborns. The medical care includes: care before, during and post pregnancy; GYN care; and newborn care. They provide this medical care in conjunction with other providers.

Words/Phrases

Free Standing Birthing Centers: Free standing birthing centers are OB-delivery facilities that are licensed by licensed by the Arizona Department of Health Services (ADHS) and certified by the Commission for the Accreditation of Free Standing Birthing Centers. These medical places have providers that offer labor and delivery services. They handle low-risk maternity care and deliveries. These facilities are contracted and close to acute hospitals in case support is needed for problem deliveries.

High-Risk Pregnancy: This is when a pregnant woman, fetus or newborn is at a higher risk for problems with the health while pregnant or after delivery. Special medical risk assessment tools are used to determine if a possible high risk situation is present.

Licensed Midwife (LM): This is a provider that has received a license from the Arizona Department of Health Services (ADHS) to do maternity care as outlined in A.R.S. Title 36, Chapter 6, Article 7, and A.A.C. R916. These providers are different than CNMs.

Maternity Care: Includes medical care for pregnancy, labor and delivery and postpartum services.

Maternity Care Coordination: Includes all services to coordinate maternity care. This includes: assessing medical and social needs; making a plan to help with the needs; helping members connect with community resources; and making sure members receive the medical and social help they need.

Maternity Care Provider:
These are types of providers that do maternity care:

1. Arizona licensed physicians who are obstetricians or general practice / family practice providers
2. Nurse practitioners
3. Physician assistants
4. Certified nurse midwives
5. Licensed midwives

Practitioner: This is CNMs, physician assistants and other nurse practitioners that do midwifery services.

Postpartum: Postpartum is 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.

Words/Phrases

Postpartum Care: This is health care given for a time 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. Family Planning services and supplies are included.

Preconception Counseling: This is helping members to identify and reduce medical and social risks that will help a woman be healthy before pregnancy. This is done by counseling that focuses on giving medical care early to reduce medical problems and behaviors to help getting pregnant and during pregnancy. This is for all women who can get pregnant whether they want to get pregnant or not. This is part of what is included in well-woman preventative medical care. It does not include genetic testing.

Prenatal Care: This is the care provided during pregnancy which includes:

1. Assessing medical and social risk
2. Providing health education
3. Ongoing medical care and treatment

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 ܟܡܡܠܠܝܬܘܢ ܣܘܪܝܬ، ܡܨܐ ܟܡܢ ܠܐܗܐ ܐܢܫܐ ܗܘ ܐܬܐ ܠܟܠܐ ܣܦܝܩܘܬܐ ܕܬܘܪܓܡܐ ܒܟܬܒܝܬܐ **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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Care1st Health Plan Arizona
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Tempe, Arizona 85281

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