



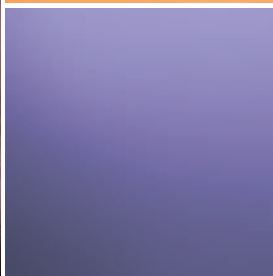
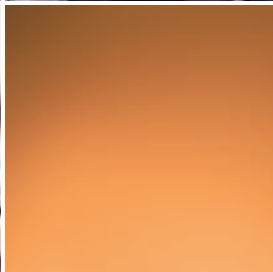
MARICOPA
HEALTH PLAN

Count on us to care.

managed by



Member Handbook



Customer Care

Statewide **1-800-582-8686**

TTY/TDD **1-800-367-8939**

Website **www.mhpaz.com**

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

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



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UPH
HEALTH PLANS

MARICOPA
HEALTH PLAN

Count on us to care.

2011 CALENDAR

<p>January</p> <p>S M T W T F S</p> <p>1</p> <p>2 3 4 5 6 7 8</p> <p>9 10 11 12 13 14 15</p> <p>16 17 18 19 20 21 22</p> <p>23 24 25 26 27 28 29</p> <p>30 31</p>	<p>February</p> <p>S M T W T F S</p> <p>1 2 3 4 5</p> <p>6 7 8 9 10 11 12</p> <p>13 14 15 16 17 18 19</p> <p>20 21 22 23 24 25 26</p> <p>27 28</p>	<p>March</p> <p>S M T W T F S</p> <p>1 2 3 4 5</p> <p>6 7 8 9 10 11 12</p> <p>13 14 15 16 17 18 19</p> <p>20 21 22 23 24 25 26</p> <p>27 28 29 30 31</p>	<p>April</p> <p>S M T W T F S</p> <p>1 2</p> <p>3 4 5 6 7 8 9</p> <p>10 11 12 13 14 15 16</p> <p>17 18 19 20 21 22 23</p> <p>24 25 26 27 28 29 30</p>
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<p>September</p> <p>S M T W T F S</p> <p>1 2 3</p> <p>4 5 6 7 8 9 10</p> <p>11 12 13 14 15 16 17</p> <p>18 19 20 21 22 23 24</p> <p>25 26 27 28 29 30</p>	<p>October</p> <p>S M T W T F S</p> <p>1</p> <p>2 3 4 5 6 7 8</p> <p>9 10 11 12 13 14 15</p> <p>16 17 18 19 20 21 22</p> <p>23 24 25 26 27 28 29</p> <p>30 31</p>	<p>November</p> <p>S M T W T F S</p> <p>1 2 3 4 5</p> <p>6 7 8 9 10 11 12</p> <p>13 14 15 16 17 18 19</p> <p>20 21 22 23 24 25 26</p> <p>27 28 29 30</p>	<p>December</p> <p>S M T W T F S</p> <p>1 2 3</p> <p>4 5 6 7 8 9 10</p> <p>11 12 13 14 15 16 17</p> <p>18 19 20 21 22 23 24</p> <p>25 26 27 28 29 30 31</p>

Appointments:

Important Phone Numbers Here:

Primary Care Physician (PCP) Name: _____

Address: _____ Phone: _____

Pharmacy: _____ Pharmacy Phone: _____

Authorized Representative(s): _____

Maricopa Health Plan Customer Care Center: Statewide 800-582-8686 or www.mhpaz.com

Medical Conditions: _____

Medications: _____

Allergies: _____

Eligibility Office: _____

Other Insurance: _____

Other Important Phone Numbers: _____

Should you go to the Emergency Room or Urgent Care?

EXAMPLES OF EMERGENCY ROOM SYMPTOMS

Extreme shortness of breath
Fainting
Poisoning
Chest pains
Uncontrolled bleeding
Seizures

EXAMPLES OF URGENT CARE SYMPTOMS

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

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Welcome & Thank You

Welcome and thank you for choosing Maricopa Health Plan (MHP) as your Arizona Health Care Cost Containment System (AHCCCS) Health Plan provider.

Maricopa Health Plan is managed by University Physicians Healthcare (UPH). University Physicians Healthcare is a group of doctors who care for patients, teach and do research through the University of Arizona College of Medicine.

Through Maricopa Health Plan, you will be able to use University Physicians medical offices and our community network of primary and specialty care providers. Maricopa Health Plan doctors take care of you and your family when you are sick and when you are well. Your medical office and Primary Care Physician (PCP) will provide the health services you need. Your health care team may include doctors, nurse practitioners and physician assistants. They work as a team to provide your care.

Language Interpretation Services

Maricopa Health Plan is proud to have members with different languages and cultures. As a member of MHP, you have access to a service that offers interpretive services for 150 different languages so that if you need this handbook or any other information in another language other than English, on audiotape, or in American Sign Language, please contact the Customer Care Center at 1-800-582-8686. Thank you.

- Arabic:** إذا كنت تحتاج إلى هذا الكتيب أو أي معلومة أخرى بلغة أخرى غير الإنجليزية، أو على شريط سمعي، أو بلغة الإشارة الأمريكية، يرجى الاتصال بأحد أعضاء فريق الخدمة على تليفون رقم 1-800-582-8686... شكرا لك.
- Chinese:** 如果您需要以英语之外的语言出版、或者以录音磁带或美国手语呈现的手册或任何其他资讯，请拨电 1-800-582-8686 与我们的会员服务部门接洽。谢谢。
- Farsi:** چنانچه به این کتاب راهنما یا اطلاعات دیگری به زبانی غیر از انگلیسی، به صورت نوار صوتی، یا به زبان اشاره نیاز دارید، لطفاً با بخش خدمات اعضاء با شماره 1-800-582-8686 تماس بگیرید. متشکریم.
- Somali:** Hadii aad rabtid buugan macluumaadka ama macluumaad kale oo ku qoran of aan english ahayn, ama iyadoo hadal ah ku duuban cajalad, ama iyadoo ah luuqad tilmaameedka gacanta (American Sign Language), fadlan kala soo xiriir xafiska adeegyada xubnaha nambarkan 1-800-582-8686. Mahadsanid.
- Spanish:** Maricopa Health Plan está orgulloso de tener pacientes provenientes de diferentes países, con distintas culturas e idiomas. Como miembro de MHP, usted tiene acceso a un servicio que ofrece servicios de traducción en 150 idiomas con el propósito de proveer este manual y otra información en otros idiomas además del inglés, en audiocasete, o en el Lenguaje de Señas Americano, comuníquese con servicios para miembros al Tel.1-800-582-8686. Gracias.
- Vietnamese:** Nếu quý vị cần số tay hướng dẫn này hoặc bất kỳ thông tin nào khác bằng ngôn ngữ khác không phải là tiếng Anh, trong băng audio, hay bằng Ngôn ngữ Cử chỉ Mỹ, xin hãy liên hệ Dịch vụ Thành viên tại 1-800-582-8686. Cảm ơn bạn.

Maricopa Health Plan offers interpretive services and printed materials to our members who need it. Please call the Customer Care Center to arrange language interpretive services in time for scheduled appointments. If you need this handbook or any other information in a language other than English, on audio tape, or in American Sign Language you may also call us. There is no cost for language interpretation services.

General Information

MHP is a Managed Care Plan. A Managed Care Plan is a health plan that provides health care to its members through a selected group of doctors, hospitals, and pharmacies. You and your doctor play an important role in a managed care plan. Your doctor helps decide what care you need, so it is important you see your doctor and talk with him or her about your health. You and your family need to have regular checkups with your doctor. Regular checkups will help keep you and your children healthy.

Terms

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

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

Key Points for Members

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

- 1) **Always carry and show your AHCCCS ID Card.**
- 2) Call your doctor's office for preventive care, regular checkups and when you need care.
- 3) Keep your medical appointments.
- 4) Make sure you have a referral from your doctor or hospital when you need to see a specialist.
- 5) Follow your PCP's orders.

Role of your Primary Care Physician (PCP)

Your Primary Care Physician (PCP) is your assigned doctor and he/she plays an important role in your health care. Your PCP will get to know you, your health needs and medical history. Your PCP will provide routine health care and arrange for any specialty care you may need. You must see your PCP before you see any other doctor, unless you have an emergency or behavioral health problem. If you are 20 years of age or younger, you can visit a dentist without visiting your PCP first. For more information on emergency room use, please see the section titled "Emergency Room & Urgent Care Use Tips" on page 23.

NOTE: Women 18 and older can have a Pap or mammogram screening once a year without a referral from their PCP.

For Member's 21 and over well visits are no longer covered. Please see excluded benefits on pages 16-17. Please contact Customer Care for more information on Pap smears, mammograms, and colonoscopies.

How to Choose or Change a Primary Care Physician (PCP)

It is important that you choose a PCP who makes you feel comfortable. When you have a PCP that you like, your PCP

will be able to help you better with your health care. This relationship is very important in providing you the care you need. You can find a list of MHP doctors on our website at www.mhpaz.com or by calling Customer Care.

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

How To Make, Change, or Cancel an Appointment

TO MAKE AN APPOINTMENT:

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

TO CHANGE AN APPOINTMENT:

- Call your doctor's office at least 24 hours ahead of time

- Tell the doctor's office:
 - Your name
 - Your Maricopa Health Plan ID number
 - The date of your appointment
 - Ask to set a new date to see your doctor

TO CANCEL YOUR APPOINTMENT:

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

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

Membership Cards

Once you become eligible for AHCCCS, you will receive a Membership Identification Card. Do not throw this card away. It is very important to carry this card with you at all times and show it when you receive medical services. This card will identify you as a Maricopa Health Plan member and lists important phone numbers and information that your Health Care Provider will need.

Only you are allowed to use your AHCCCS card for Health Care Services. Never lend, sell, or allow someone to use your card. This is against the law, and you might lose your AHCCCS eligibility. Legal action may also be taken against you

YOU WILL NEED YOUR AHCCCS MEMBER ID CARD TO:

- Make doctor appointments
- See your doctor
- Get medicine and supplies
- Get care from a hospital or other medical provider
- Get help and information from the Customer Care Center

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

The Customer Care Center

The Customer Care Center is staffed by English and Spanish speakers who are here to help you get the medical care you need. You can call the Customer Care Center at 1-800-582-8686, or if you are a TTY user you can contact the Arizona Relay System at 1-800-367-8939.

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

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



SOME OF THE WAYS WE CAN HELP YOU ARE:

- Answer questions about your covered services, benefits, and co-pays
- Provide information about doctors, nurse practitioners, and physician assistants
- Provide information about programs available to members
- Help you choose or change your PCP
- Help you understand Maricopa Health Plan
- Help you schedule a ride to your doctor or medical appointments
- Help you make, change or cancel your medical appointments
- Provide you with dentist or specialist information
- Help you if you have a complaint or problem
- Help you with your rights as a member
- Help you schedule a Language Interpreter for your medical appointments if you cannot communicate with your doctor. This service is provided at no cost to you.
- Help you change your phone number and address with AHCCCS.

If you are currently being treated for conditions such as diabetes, cancer, asthma, behavioral health, HIV/AIDS, or any disability, call Customer Care immediately. We will refer you to a Case Manager to make sure you are getting the care you need.

Annual Enrollment Choice (AEC)

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

Renewing AHCCCS Coverage

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

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

- Stop getting TANF
- Stop getting food stamps
- Stop getting SOBRA

If you don't know why you are no longer enrolled, call AHCCCS at 1-800-654-8713.

Health Plan Changes

There are certain reasons why you may change your health plan outside of your normal Annual Enrollment Choice (AEC) period.

1. You were not given a choice of health plans.
2. You did not get your AEC letter.
3. You got your AEC letter but were not able to take part in your AEC due to things out of your control.

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

- Call your local D.E.S. eligibility office with your new address and phone number.
- Call Customer Care with your new address and phone number.
- KidsCare members can call 1-877-764-5437 toll free.

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

If you need to change your health plan due to any of the above reasons, please call AHCCCS at 1-800-654-8713. If there is another reason why you must change your health plan, or you have questions about changing your health plan, please call Customer Care.

What to Do when your Family Size Changes

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

EACH NEW PERSON IN YOUR FAMILY MUST BE MADE ELIGIBLE FOR AHCCCS. YOU MUST CALL THE OFFICE THAT MADE YOU ELIGIBLE FOR AHCCCS TO ADD A NEW MEMBER OR IF ANY FAMILY MEMBER LEAVES AND YOUR FAMILY BECOMES SMALLER. IF YOU HAVE ANY QUESTIONS, CALL THE MHP CUSTOMER CARE CENTER.

members are covered by Maricopa Health Plan.

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

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

Moving

WHAT IF YOU ARE MOVING AWAY FROM THE SERVICE AREA?

If you move out of the country, the state of Arizona or out of your county, your current plan will no longer be valid if you move outside of your service area.

Before you move, tell:

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

Call Customer Care if you have questions about your enrollment or call AHCCCS at 602-417-4000.

Cultural Competency

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

MHP knows that your health is affected by your beliefs, culture, and values. We want to help you keep and maintain good health and good relationships with doctors who understand your needs. If you feel that there is a problem, please contact us. We will help you find a provider who will better understand your personal needs.

MHP provides language interpretive services for members at no cost to you. If you cannot speak to your provider because of a language barrier, please contact Customer Care. We can schedule an interpreter to help with appointment.

If you need this or any of our other printed materials in another language, please call Customer Care.

Call us and let us know if we have overlooked anything that is important to you. We will try to help. We want you to be comfortable with the people and services that make up Maricopa Health Plan.

ASK ME 3

Maricopa Health Plan offers an exciting program called Ask Me 3. It will help you talk with your doctor.

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

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

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

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


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

Partnership for Clear Health Communication

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

How can your Doctor help you stay Healthy?

- Make sure children ages 0 – 20 receive their annual well-exams and immunizations.
- Adults ages 21 and older should visit their PCP when a symptom or sickness develops.
- Schedule preventative exams such as Pap, mammogram, and cancer screenings once a year. Colonoscopies can be scheduled once every five to ten years. For Member's 21 and over well visits are no longer covered. Please see excluded benefits on pages 16-17. Please contact Customer Care for more information on Pap smears, mammograms, and colonoscopies.
- Keep your appointment for tests that your doctor has ordered for you.
- Know why it is important for you to have the test done and what could happen if you don't have it done.
- Ask your doctor to help you learn how to take better care of yourself.



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

Covered Services (including Dental and Behavioral Health)

As a member of Maricopa Health Plan, you may receive the following health care benefits. The list below does not include all possible services. Your PCP may be providing you these services or he/she may make plans for you to get these services from another provider (sometimes called a specialist).

You must see your PCP before you see any other provider or attempt to get outside services. You do not have to see your PCP if you are having an emergency, a behavioral health problem, or need OB/GYN services. Children ages 0 – 20 may visit a dentist without a referral from a PCP.

Please remember that KidsCare members have benefits through the age of 18.

For our members, the care listed below will be covered by MHP. Call or write MHP Customer Care for more facts about these services:

- Ambulance for emergency care
- Behavioral Health Care
- Care while you are pregnant
- Case management
- Checkups for children, pregnant women, QMB, and SMI members
- Children's services including routine dental care
- Chiropractic services for children and QMB members
- Emergency medical and surgical services related to dental (oral) care ▲
- Dialysis
- Disease Management
- Emergency or Urgent Care medical treatment
- Eyeglasses or contacts for children, or adults only after cataracts are removed
- Family planning / birth control
- Health care services through screenings, diagnosis and medically necessary treatment for members 21 years of age or older

- Hospice care for EPSDT members
- Hospital care
- Lab work and x-rays
- Medical tests
- Medically needed foot care not given by a podiatrist
- Medicine from the approved drug list, the MHP Drug Formulary
- PCP office visits for children, QMB, SMI, or when an adult has a symptom or sickness
- Preventative and routine gynecological (GYN) services for female members (direct access, no referral needed)
- Rides to health care visits
- Second opinions: You have the right to have a second opinion from a qualified health care professional within the network. If one is not available in the network, you have the right to arrange for a second opinion outside the network at no cost to you.
- Supplies and equipment, including MHP Drug Formulary diabetic testing equipment and supplies ▲
- Well-child checkups including dental, hearing, shots and vision care.

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

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

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

Approval and Denial Process:

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

Your PCP's office will let you know when authorization is obtained. You can also call Customer Care to find out the status of the request.

MHP will let you know by mail if authorization is denied. In the letter, you will have instructions on how to file an appeal. The letter will describe the reason for the denial. For further questions, call Customer Care. If you have a question about the denial and need help, please call Customer Care or write to us at the address listed on the cover of this handbook. Please see page 24 for more information about filing an appeal about a denied authorization.

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

Home and Community Based Services (HCBS)

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

Hospital Care

- Blood and blood plasma
- Intensive care
- Laboratory, x-ray and imaging services
- Medicines
- Nursing care
- Operating room and hospital care
- Services of doctors, surgeons, specialists

Case Management

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

Disease Management

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

Tobacco Education and Prevention

The Maricopa Health Plan Tobacco Cessation Program offers a number of nicotine replacement products (patches, lozenges, gum) and

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

Dental Care

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

At 12 months of age children should begin to see a dentist for a checkup every six months. MHP sends dental checkup reminder postcards. Dentists can help prevent cavities. They can use dental sealants (a plastic coating painted on the back teeth) and fluoride treatments. Dentists also teach you and your child how to care for teeth. It is important for your child to go to the dentist two times every year.

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

Use these guidelines for scheduling appointments for your child:

- Emergency dental appointments – same day appointments; for extreme pain and dental emergencies.
- Urgent dental appointments – within 3 days for lost fillings, broken tooth.
- Routine dental appointments – within 45 days, for routine checkups and dental cleanings.

Make sure you take your child's AHCCCS ID card with you to the dental appointment.

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

Any member ages 21 years and older can only receive emergency dental services if you have a need for care immediately like a bad infection in your mouth or pain in your teeth or jaw. Pre-transplantation members can also get emergency dental service. Please call Customer Care for a listing of approved services.

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

Medically necessary means a covered service is provided by a physician or other licensed practitioner of the healing arts within the scope of practice under state law to prevent disease, disability or other adverse health conditions or their progression, or prolong life.

Pharmacy Services

PRESCRIPTIONS

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

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

Some over-the-counter medicines are also covered when a prescription is written by your PCP. All prescriptions should be filled at a pharmacy listed in your Provider Directory. If you have other insurance, Maricopa Health Plan will only pay the co-pays if the drug is also on the Maricopa Health Plan drug list.

WHAT YOU NEED TO KNOW ABOUT YOUR PRESCRIPTION

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

Carefully read the drug information the pharmacy will give you when you fill your prescription. It will explain what you should and should not do and possible side effects.

REFILLS

The label on your medication bottle tells you how many refills your doctor has ordered for you. If your doctor has ordered refills, you may only get one refill at a time.

If your doctor has not ordered refills, you must call him/her **AT LEAST FIVE (5) DAYS** before your medication runs out. Talk to him/her about getting a refill. The doctor may want to see you before giving you a refill.

Behavioral Health Services

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

BEHAVIORAL HEALTH EMERGENCIES

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

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

- Call Customer Care during business hours and ask for the Behavioral Health Coordinator or Behavioral Health Case Manager
- Call your PCP

If you have a serious mental illness or you want counseling, behavioral health benefits are provided through your Regional Behavioral Health Authority (RBHA).

BEFORE YOU LEAVE THE OFFICE, ASK THESE QUESTIONS:

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

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

Your AHCCCS card may have the phone number of the provider (Regional Behavioral Health Authority or RBHA) that will give you behavioral health or substance abuse services. You are assigned to a provider (RBHA) based on where you live. The provider (RBHA) will pay for most behavioral health services including most prescriptions for behavioral health conditions. If your card does not list the provider (RBHA) you are assigned to, please refer to the listing on page 9 or call Customer Care for assistance.

BEHAVIORAL HEALTH SERVICES THAT YOU MAY BE ELIGIBLE FOR INCLUDE:

- a. Behavior Management (behavioral health personal care, family support/home care training, self-help/peer support)
- b. Behavioral Health Case Management Services (limited)
- c. Behavioral Health Nursing Services
- d. Emergency Behavioral Health Care
- e. Emergency and Non-Emergency Transportation
- f. Evaluation and Assessment
- g. End of Life Care
- h. Individual, Group and Family Therapy and Counseling
- i. Inpatient Hospital Services
- j. Institutions for Mental Diseases
- k. Non-Hospital Inpatient Psychiatric Facilities Services (Level I residential treatment centers and sub-acute facilities)
 - l. Laboratory and Radiology Services for Psychotropic Medication Regulation and Diagnosis
- m. Partial Care (supervised day program, therapeutic day program and medical day program)
- n. Psychosocial Rehabilitation (living skills training; health promotion; supportive employment services)
- o. Psychotropic Medication
- p. Psychotropic Medication Adjustment and Monitoring
- q. Respite Care (with limitations)
- r. Rural Substance Abuse Transitional Agency Services
- s. Screening
- t. Therapeutic Home Care Services (formerly known as Therapeutic Foster Care)
- u. Opioid Against Treatment

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

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

BEHAVIORAL HEALTH TRANSPORTATION

If you are receiving behavioral health services through a RBHA office, please call RBHA if you need help in getting to your appointment.

Medically Necessary Pregnancy Terminations

Pregnancy terminations are an AHCCCS covered service only in special situations. Pregnancy termination is covered if the life of the mother is in danger due to the pregnancy or the pregnancy is due to rape or incest.



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

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

Women Health Screening

Woman should get preventative screenings each year. These exams may include a Pap smear and a mammogram. For Member's 21 and over well visits are no longer covered. Please see excluded benefits on pages 16-17. Please contact Customer Care for more information on Pap smears, mammograms, and colonoscopies.

A Pap smear tests for early stages of cervical cancer.
A mammogram tests for breast cancer.

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

Family Planning

Family Planning services are available to both male and female members. Family Planning will help you decide when to have children. Our providers can help you choose birth control methods that will work for you. Family Planning services require no co-payment and are offered at no cost to you. You may seek family planning services from any network PCP or Gynecologist. No referral is needed from your PCP.

You may not want to get pregnant if you:

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

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

- Birth control pills or shots, condoms, diaphragms, foams
- Natural family planning and referral to qualified health professionals
- Post-coital emergency contraception (also known as the morning after pill)
- Sterilization (male and female) only for members 21 years of age or older

The following services are covered under Family Planning:

- Medical exams including ultrasound for family planning
- Laboratory tests for family planning
- Treatment for complications from birth control use including emergency treatment

The following services are not covered under Family Planning:

- Infertility services including testing, treatment, or reversal of a tubal sterilization or vasectomy
- Pregnancy termination counseling
- Pregnancy termination – unless you meet the conditions described in the Pregnancy Termination Section
- Hysterectomies if done for family planning only

Family Planning Extension Program

Members who lose AHCCCS/SOBRA eligibility can receive no cost/low cost family planning and primary care services through the Family Planning Extension program for up to 24 months. Services available through the Family Planning Extension programs include primary care services, STD treatment, and contraception. Services are available at:

CARE Partnership

466 S. Bellview
Mesa, AZ 85204
480-833-8987

**No cost family planning for teens with no income*

Maricopa County Department of Health

1645 E. Roosevelt St.
Phoenix, AZ 85006
602-506-6635

Maricopa County Health Care for the Homeless

220 S. 12th Ave.
Phoenix, AZ 85007
602-372-2100

**Must be homeless to use services*

Adelante Healthcare – Phoenix

7725 N. 43rd Ave., Ste. 510
Phoenix, AZ 85051
877-809-5092

Adelante Healthcare – Buckeye

306 E. Monroe
Buckeye, AZ 85326
877-809-5092

Adelante Healthcare – Surprise

16560 N. Dysart Rd.
Surprise, AZ 85374
877-809-5092

Adelante Healthcare – Mesa

2204 S. Dobson Road, #101
Mesa, AZ 85202
877-809-5092

Adelante Healthcare – Sun City West

14300 W. Granite Valley Drive
Sun City West, AZ 85375
623-544-3214

Adelante Healthcare – Gila Bend

100 N. Gila Blvd.
Gila Bend, AZ 85337
877-809-5092

Adelante Healthcare – Wickenburg

811 N. Tegner, Ste. 113
Wickenburg, AZ 85390
877-809-5092

East Valley Family Care

2204 Dobson Road, #101
Mesa, AZ 85202
480-491-6235 (main office)

Adelante Women's Health Care

14300 W. Granite Valley Drive
Sun City West, AZ 85375
623-544-3214



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Maternity Care

MATERNITY CARE DEFINITIONS

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

LICENSED MIDWIFE means an individual licensed by the Arizona Department of Health Services to provide maternity care pursuant to Arizona Revised Statutes (A.R.S.)

Title 36, Chapter 6, Article 7 and Arizona Administrative Code Title 9, Chapter 16. (This provider type does not include certified nurse midwives licensed by the Board of Nursing as a nurse practitioner in midwifery or physician assistants licensed by the Arizona Medical Board.)

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

MATERNITY CARE COORDINATION consists of the following maternity care related activities: determining the member's medical or medical/social needs through a risk assessment

evaluation; developing a plan of care designed to address those needs; coordinating referrals of the member to appropriate service providers; monitoring to ensure the services are received and revising the plan of care as appropriate.

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

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



PRECONCEPTION COUNSELING

focuses on the early detection and management of risk factors before pregnancy, and includes efforts to influence behaviors that can affect a fetus (even before conception is confirmed) as well as regular health care. The purpose of preconception counseling is to ensure that a woman is healthy prior to pregnancy.

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

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

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

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

If your pregnancy is high-risk, MHP offers OB case management to our members at no cost to you. Our case management staff is specially trained to help you through your pregnancy and after you deliver. They are here to answer questions and help you with any appointments or referrals you might need. If you have any concerns or

would like to talk to one of our case managers, please call 1-877-874-3933.

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

Please call your provider to schedule your first appointment.



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

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

You will be given important information on:

- Having a healthy baby by eating right, exercising and rest
- Things to do or not to do while pregnant
- Normal changes to expect during pregnancy
- Preparing for the birth of your baby
- Childbirth classes
- Preparing for the care of your baby
- Family planning (with the exception of abortions and abortion counseling)

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

Prenatal Care

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

Members who have a high risk or problem pregnancy can get case management help from MHP. Please

contact Customer Care if you need help with your pregnancy.

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

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

- Fourteen (14) days if you are in your first trimester
- Seven (7) days if you are in your second trimester
- Three (3) days if you are in your third trimester
- Three (3) days if your pregnancy is high-risk or immediately if it is an emergency.

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

DURING YOUR PREGNANCY:

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

AFTER YOUR PREGNANCY:

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

Women, Infants and Children (WIC)

As a member of MHP, you may be eligible for the WIC program. WIC helps families with young children get food, formula and

even offers nutrition classes. For more information or help finding a WIC office near you, please call the Maternal Child Health OB Case Manager at 1-877-874-3933.

Well-child Care / Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

MHP wants to help your children grow up healthy. Early Periodic Screening, Diagnostic and Treatment (EPSDT) is a comprehensive child health program of prevention and treatment, correction, and improvement (amelioration) of physical and mental health problems for AHCCCS members under the age of 21. The purpose of EPSDT is to ensure the availability and accessibility of health care resources, as well as to assist Medicaid recipients in effectively utilizing these resources. EPSDT services provide comprehensive health care through primary prevention, early intervention, diagnosis, medically necessary treatment, and follow-up care of physical and behavioral health problems for AHCCCS members less than 21 years of age. EPSDT services include screening services, vision services, dental services, hearing services and all other medically necessary mandatory and optional services listed in federal law 42 USC 1396d(a) to correct or ameliorate defects and physical and mental illnesses and conditions identified in an EPSDT screening whether or not the services are covered under the AHCCCS state plan. Limitations and exclusions, other than the requirement for medical necessity and cost effectiveness do not apply to EPSDT services.

A well child visit is synonymous with an EPSDT visit and includes all screenings and services described in the AHCCCS EPSDT and dental periodicity schedules.

Amount, Duration and Scope: The Medicaid Act defines EPSDT services to include screening services, vision services, dental services, hearing services and “such other necessary health care, diagnostic services, treatment and other measures described in federal law subsection 42 USC 1396d(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the (AHCCCS) state plan.” This means that EPSDT covered services include services that correct or ameliorate physical and mental defects, conditions, and illnesses discovered by the screening process when those services fall within one of the 28 optional and mandatory categories of “medical assistance” as defined in the Medicaid Act. Services covered under EPSDT include all 28 categories of services in the federal law even when they are not listed as covered services in the AHCCCS state plan, AHCCCS statutes, rules, or policies as long as the services are medically necessary and cost effective.

EPSDT includes, but is not limited to, coverage of: inpatient and outpatient hospital services, laboratory and x-ray services, physician services, nurse practitioner services, medications, dental services, therapy services, behavioral health services, medical supplies, prosthetic devices, eyeglasses, transportation, and family planning services. EPSDT also includes diagnostic, screening, preventive and rehabilitative services. However, EPSDT services do not include services that are solely for cosmetic purposes, or that are not cost effective when compared to other interventions.

There is no co-pay for these services. Every growing child should have each of these well-child checkups. These are routine exams especially to keep children healthy.

These checkups can help find some health problems early so that they can be treated. Treatment will keep them from becoming more serious. All medically necessary services to treat a physical or mental illness found during a well-child care exam are covered. If your child needs behavioral help, talk to your PCP.

The Well-child program includes:

- A. Checkups
 - A complete unclothed physical exam
 - Developmental/behavioral screenings
 - Growth measurements
 - Nutrition information
 - Oral health screening
 - Education about healthy living
 - Immunizations – Documentation of all immunizations is required
 - TB (Tuberculosis) Screening
- B. Tests
 - Eye test and glasses/contacts, if needed
 - Hearing test and hearing aid(s), if needed
 - Lab tests (including lead screening tests)
- C. Services (including, but not limited to)
 - Case management
 - Chiropractic care if your PCP orders this service and under certain conditions
 - Care by specialists, if needed
- D. Medicines listed in the MHP Drug Formulary
- E. Special medical foods when medically necessary

Well-child care will also give you ideas about how to:

- Keep your child well
- Protect your child from getting hurt
- Spot health problems early
- Apply for services like WIC, Head Start, Children’s Rehabilitative Services (CRS), and the Arizona Early Intervention Program (AzEIP)

All children should see their doctor for well-child visits regularly. Well-child checkups should be done at the following ages:

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

MHP will send you a reminder about well-child checkups. Make an appointment with your PCP. It is important for your child to go to all the well-child checkups.

Children with Special Health Care Needs

As of July 1, 2006, MHP began coverage for incontinence briefs (diapers), including pull-ups for members age 3 years to 20 years old with a documented medical health need. Any approval for incontinence briefs is good for one year. MHP will help children with Special Health Care Needs receive additional help with services that may be provided by Children’s Rehabilitative Services (CRS). If you have questions about this benefit, please call the Maternal Child Health Program at 1-877-874-3933, extension 5.

Early Childhood Services

If you are concerned that your child is not growing like other children of the same age, tell your pediatrician or family doctor. Your doctor can refer you to specialists to learn if your child is on track with talking, moving, using hands and fingers, seeing and hearing. If your child is behind in one or more of these areas, services are available to help you help your child improve

in these areas. The doctor may refer you to the Arizona Early Intervention Program (AzEIP) if your child is birth to three years of age and has a delay. To learn more about other community programs for children with special needs call the Maternal Child Health Program at 1-877-874-3933, extension 5.

Head Start

Arizona Head Start Programs provide high quality programs for preschool age children that include early childhood education, nutrition, health, mental health, disabilities and social services. There are Head Start Services at over 500 locations throughout the state of Arizona. MHP will help you enroll your child in a Head Start Program near your home if needed. If you need additional information about Head Start, please call the Maternal Child Health Program at 1-877-874-3933, extension 5.

Parental Evaluation of Developmental Status (PEDS) Tool

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

Additional Community Resources

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

www.myazhealthandwellness.com

www.MyAHCCCS.com



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Benefit Changes

Changes to Covered Services Effective October 1, 2010

Due to Arizona's huge budget problems and more people being added to the Medicaid Program, after 10/1/2010, Maricopa Health Plan, under the direction of the AHCCCS Administration, will no longer pay for certain medical care for anyone who is 21 years old or older. If you are a Qualified Medicare Beneficiary, we will continue to pay your Medicare deductible and coinsurance for these services.

The medical services that will no longer be covered are:



BENEFIT/ SERVICE	SERVICE DESCRIPTION	SERVICE EXCLUDED FROM PAYMENT
Insulin Pumps	A machine that is worn to give insulin through the day to a person as needed.	AHCCCS will not pay for insulin pumps. Supplies, equipment maintenance (care of the pump) and repair of pump parts will be paid for.
Percussive Vests	This vest is placed on a person's chest and shakes to loosen mucous.	AHCCCS will not pay for percussive vests. Supplies, equipment maintenance (care of the vest) and repair of the vest will be paid for.
Bone-Anchored Hearing Aid	A hearing aid that is put on a person's bone near the ear by surgery. This is to carry sound.	AHCCCS will not pay for Bone-Anchored Hearing AID (BAHA). Supplies, equipment maintenance (care of the hearing aid) and repair of any parts will be paid for.
Cochlear Implant	A small device that is put in a person's ear by surgery to help you hear better.	AHCCCS will not pay for cochlear implants. Supplies, equipment maintenance (care of the implant) and repair of any parts will be paid for.
Lower limb Microprocessor controlled joint/ Prosthetic	A device that replaces a missing part of the body and uses a computer to help with the moving of the joint.	AHCCCS will not pay for a lower limb (leg, knee or foot) prosthetic that includes a microprocessor (computer chip) that controls the joint.
Orthotics	A support or brace for weak joints or muscles. An orthotic can also support a deformed part of the body.	AHCCCS will no longer pay for orthotics. Supplies, equipment maintenance and repair of component parts will be paid for. Orthotics means items like leg braces, wrist splints and neck braces. Maintenance (care of existing orthotics) and repair of parts will still be paid for.

BENEFIT/ SERVICE	SERVICE DESCRIPTION	SERVICE EXCLUDED FROM PAYMENT
Emergency Dental Service	Emergency services are when you have a need for care immediately like a bad infection in your mouth or pain in your teeth or jaw.	<p>AHCCCS will not cover dental services (including emergency dental services) unless the care needed is a medical or surgical service related to dental (oral) care. Covered dental services for members 21 years of age and older must be related to the treatment of a medical condition such as acute pain, infection, or fracture of the jaw. Covered dental services include examining the mouth, x-rays, care of fractures of the jaw or mouth, giving anesthesia, and pain medication and / or antibiotics.</p> <p>Certain pre-transplant services and prophylactic extraction of teeth in preparation for radiation treatment of cancer of the jaw, neck or head is also covered.</p>
Services by Podiatrist	Any service that is done by a doctor who treats feet and ankle problems.	AHCCCS will not pay for services provided by a podiatrist or podiatric surgeon for adults. Contact your health plan for other contracted providers who can perform medically necessary foot and ankle procedures, including reconstructive surgeries.
Well Exams	Well exams are when a person visits the doctor for a check up when they are not sick.	Well visits are not paid for. Well visits are when a person goes to the doctor's office for a routine check up instead of going for a cold or some other sickness or problem. However, Pap smears, mammograms, and colonoscopies will still continue to be covered.
Transplants	A transplant is when an organ or blood cells are moved from one person to another.	<p>The following non-experimental transplants will not be paid for, even for members on a waiting list, on or after 10/1/2010 with the exception that if the member is in the "prep and transplant" phase or follow up care, then the transplant and all subsequent care is covered. That means that you would need to be in the hospital being prepared for surgery with your donor organ or bone marrow having arrived by 10/1/2010.</p> <p>The following transplant types will not be paid for if a new request is received after 9/30/10 or a transplant has not been started by 10/1/10:</p> <ul style="list-style-type: none"> ■ Pancreas only transplants (total, partial or islet cell) ■ Pancreas after kidney transplants ■ Lung transplants ■ Allogeneic unrelated hematopoietic cell (bone marrow) transplants ■ Liver transplants for members with a diagnosis of Hepatitis C ■ Heart transplants for non-ischemic cardiomyopathies. <p>Non-ischemic cardiomyopathy is defined as a condition in which the underlying cardiac abnormality has not resulted in irreversible permanent damage to the heart muscle. Members with "non-ischemic cardiomyopathy" have sufficient cardiac function to circulate adequate volumes of blood and oxygen to the heart muscle and other body organs</p> <ul style="list-style-type: none"> ■ Any other transplant not listed by AHCCCS as covered. <p>You can speak with your health plan for a list of transplants that would be paid for. 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.</p>
Physical Therapy	Exercises taught or provided by a Physical Therapist to make you stronger or help improve movement.	Outpatient physical therapy visits are limited to 15 visits per contract year (10/1–9/30). The member who has Medicare should talk to the health plan for help in determining how the visits will be counted.

Co-payments

AHCCCS CO-PAYMENTS FOR MED AND AHCCCS CARE MEMBERS BEGINNING NOVEMBER 1, 2010

Co-payments for AHCCCS members will change starting on October 1, 2010. Inside the Member Handbook you can read about the changes for AHCCCS members who are NOT eligible for MED or AHCCCS Care.

Because there is a lawsuit about co-payments for members in MED and AHCCCS Care, co-payments for these members may be different, and they can change during the next year. You can find out what co-payments you have by calling the Maricopa Health Plan Customer Care Center at 1-800-582-8686 or by going to myahcccs.com. You can also ask your provider to look up your eligibility to tell you what co-payments you have. The health plan website at www.mhpaz.com also has information about co-payments.

This section tells you about the co-payments for members in the MED and AHCCCS Care programs. If you are in MED or AHCCCS Care, these co-payments start November 1, 2010.

Members in the MED Program are people with high medical expenses who are not eligible for any other AHCCCS Program because of their income.

Members in AHCCCS Care are adults who:

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

Members in MED and AHCCCS Care are asked to pay higher co-payments for some of the AHCCCS medical services they receive. Members in MED and AHCCCS Care are required to pay the co-pays. This means that members need to pay these co-payments in order to get services. Pharmacists and medical providers can refuse services if the co-pay is not paid.

There are some MED and AHCCCS Care members who are never asked for co-payments. There are also some services that never have co-payments.

THE FOLLOWING PERSONS IN MED AND AHCCCS CARE ARE NEVER ASKED TO PAY CO-PAYMENTS:

- Children under age 19
- People determined to be Seriously Mentally Ill (SMI) by the Arizona Department of Health Services

- Individuals up through age 20 eligible to receive services from the Children's Rehabilitative Services program
- People who are in nursing homes, residential facilities such as an Assisted Living Home or who receive Home and Community Based Services such as attendant care or a visiting nurse
- People who receive hospice care

ALSO, CO-PAYMENTS ARE NEVER CHARGED FOR THE FOLLOWING SERVICES:

- Hospitalizations
- Emergency services
- Family Planning services and supplies
- Pregnancy related health care including tobacco cessation treatment for pregnant women
- Services paid on a fee-for-service basis

Ask your provider to look up your eligibility to find out what co-pays you may have. You can also find out by calling Maricopa Health Plan Customer Care Center at 1-800-582-8686 or by going to myahcccs.com. You can also check your health plan's website at www.mhpaz.com for more information.

NOMINAL (LOW) CO-PAYS FOR SOME AHCCCS PROGRAMS

Most people who get AHCCCS benefits are asked to pay the following nominal co-payments for medical services:	
Prescriptions	\$2.30
Outpatient services for physical, occupational and speech therapy	\$2.30
Doctor or other provider outpatient office visits for evaluation and management of your care	\$3.40

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

PEOPLE WITH REQUIRED CO-PAYMENTS

1. Families with Children who are no Longer Eligible Due to Earnings – Transitional Medical Assistance (TMA)

If a family is no longer eligible for any AHCCCS program due to higher income that they get from working, they may still get AHCCCS benefits through the Transitional Medical Assistance (TMA) program. Adults on TMA have to pay higher co-pays for some medical services and will need to pay the co-pays in order to get the services. If you are on the TMA Program now or if you become eligible to receive TMA benefits later, the notice from DES will tell you so.

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

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

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

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

If you think that your income or circumstances have changed, contact your eligibility office right away.

2. People with High Medical Expenses Who Are not Eligible for any Other AHCCCS Program Because of Their Income-MED Program

People with high medical expenses who are not eligible for any other AHCCCS program because of their income, may get AHCCCS benefits through the Medical Expense Deduction (MED) program. People on MED have to pay higher co-pays for some medical services and will need to pay the co-pays in order to get the services.

BEGINNING NOVEMBER 1 2010, MEMBERS IN MED AND AHCCCS CARE HAVE THE FOLLOWING REQUIRED CO-PAYMENTS:

CO-PAYMENT AMOUNTS FOR PERSONS IN MED AND AHCCCS CARE

SERVICE	COPAYMENT
Generic Prescriptions and Brand Name Prescriptions when there is no generic	\$4.00
Brand Name Prescriptions when there is a generic that can be used	\$10.00
Non-emergency use of an emergency room	\$30.00
Doctor office visits	\$5.00

Pharmacists and Medical Providers CAN REFUSE services if the copayments are not made.

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

IMPORTANT: Remember that the co-pays for people in the MED and AHCCCS Care programs may change because of a lawsuit. The co-pays that are listed on this page start November 1, 2010. If the co-pays change, we will tell you so.

3. Other Adults – AHCCCS Care Program

An adult may get AHCCCS benefits through the AHCCCS Care Program. An adult is on AHCCCS Care because the adult:

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

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

There may be a small fee for some services.

EXCEPTION: Native American Contractor Enrolled Parents are exempt from any co-payment.

Non-covered Services

- Non-emergency services that are not prior approved by your PCP.
- Any care, treatment, or surgery that is not medically necessary.
- Infertility services that include testing and treatment.
- Reversals of elective sterilization.
- Sex changes.
- Exams to establish the need for hearing aids, glasses, or contacts for members 21 years and older, except after cataract surgery.
- Hearing aids, eye glasses, or contacts for members 21 years and older, except after cataract surgery.
- Services or items for cosmetic reasons.
- Personal or comfort items (only covered for EPSDT, if medically indicated).
- Non-prescription drugs or supplies (except insulin and insulin syringes).
- Private or special duty nurses.
- Services given in an institution for the treatment of tuberculosis (TB).
- Medical service given to an inmate or to a person in the custody of a state mental health institution.
- Outpatient speech and occupational therapy for members 21 years and older.
- Lower limb microprocessor controlled joint/prosthetic for members 21 years of age and older.
- Any service determined as experimental/investigational or done mainly for research or that has not been approved by regulating agencies.
- **Transplants including:**
 - Pancreas only transplants (total, partial or islet cell)
 - Pancreas after kidney transplants
 - Lung transplants
 - Allogeneic unrelated hematopoietic cell (bone marrow) transplants
 - Liver transplants for members with a diagnosis of Hepatitis C
 - Heart transplants for non-ischemic cardiomyopathies. Non-ischemic cardiomyopathy is defined as a condition in which the underlying cardiac abnormality has not resulted in irreversible permanent damage to the heart muscle. Members with “non-ischemic cardiomyopathy” have sufficient cardiac function to circulate adequate volumes of blood and oxygen to the heart muscle and other body organs.
 - Any other transplant not listed by AHCCCS as covered.
- Physical exam for non-medical purposes (for example, job or insurance exams).
- Well Exams for members ages 21 and older (visits to the doctor when member is not sick).
- Abortion counseling and abortions (unless medically necessary per AHCCCS medical policies).
- Any medical services outside of the country.
- Routine/newborn circumcisions.
- Norplant.
- Routine health care (out-of-area).

You may be billed for any non-covered services you choose to receive. In special cases you may be able to get services outside of your service area. Please contact the Customer Care Center if you would like more information about this.

PAYING FOR NON-COVERED SERVICES

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

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

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

SERVICES NOT APPROVED BY MHP

If MHP does not approve care or medicine ordered by your PCP, you will receive a written notice of action. The notice of action will be mailed within fourteen (14) calendar days from when the request was received. The notice will explain why this service was

denied. You will receive a written notice at least 10 days before MHP reduces, stops or ends a service that you have been getting. The notice you receive will tell you how to appeal this decision if you do not agree. You may file an appeal either verbally or in writing. It must be done through MHP within sixty (60) days from the date of the notice of action. MHP will provide you with a written decision within thirty (30) days of filing the appeal.

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

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

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

BILLING FOR A COVERED SERVICE

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

Other Benefits

Referrals to Specialists

MEDICAL SERVICES:

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

If your PCP's request is denied, MHP will let you know by mail. If you have a question about the denial, you may call Customer Care or write to us at the address listed on the front of this handbook. Please see page 24 for more information about filing an appeal for a denied authorization. The letter sent by MHP will also tell you how to request a hearing directly with AHCCCS.

NOTE: Women 18 and older can have a Pap or mammogram screening once a year without a referral from their PCP.

For Member's 21 and over well visits are no longer covered. Please see excluded benefits on pages 16-17. Please contact Customer Care for more information on Pap smears, mammograms, and colonoscopies.

Behavioral Health Services:

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

- Your PCP
- Customer Care
- MHP Behavioral Health Coordinator during business hours
- Your Regional Behavioral Health Authority (RBHA)

Please refer to page 9 for a more complete description of services available.

Coordination of Benefits (COB)

If you are a member with "other insurance" or are "dual eligible" (which means that you also have Medicare coverage), please take a moment to call Customer Care to let us know. When you call us, we will make sure we have the other insurance listed in our system. You may also call the AHCCCS eligibility office to let them know. AHCCCS will then pass the information on to us. Remember, this also includes insurance coverage by divorce or if your child had insurance that is paid by your former spouse.



Sometimes, members with other types of insurance such as Tricare or other commercial plans are approved for AHCCCS. Maricopa Health Plan is responsible for making any co-payment, coinsurance or deductibles, even if the services are provided outside of the Maricopa Health Plan Network.

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

- The Primary Insurance Paid amount and the Primary Insurance Rate (i.e., the member's co-payment required under the Primary Insurance, OR
- The Primary Insurance Paid amount and the AHCCCS Fee for Service Rate,

even if the services are provided outside of the network. MHP is not responsible for paying coinsurance and deductibles that are more than MHP would have paid for the entire service per the contract with the provider performing the service, or the AHCCCS equivalent.

SPECIAL INFORMATION FOR OUR MEMBERS WHO HAVE MEDICARE COVERAGE:

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

If you have Medicare coverage and you see a doctor that is not on our plan, the charges may not be covered. If you choose to do that without our approval, Maricopa Health Plan may not pay for those services because they were done by a doctor that is not on our plan. It is important that you work with your PCP to be referred to the right doctors. (This does not include

emergency services.) Maricopa Health Plan will not cover co-pays or deductibles for services provided outside of the network without authorization.

So why should you call Customer Care and let us know? Because it will help you get the maximum benefits from both insurance plans!

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

Transportation: Rides to Medical Appointments

EMERGENCY

Your condition is a medical emergency when your life, body parts or bodily functions are at risk of damage or loss unless immediate care is received.

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

NON-EMERGENCY

There are several ways in which members can get rides to doctor appointments. The easiest way is to find a ride with a family member or a friend.

BUS TICKETS

You can contact Customer Care to see if you qualify for bus tickets to go to medically necessary visits. Providers must be in our network to use bus tickets.

TAXI RIDES

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

On weekends and holidays, you can call Customer Care for taxi rides to urgent care centers when you are sick. Always remember

to dial 911 in a true medical emergency.

CAR SEAT, WHEELCHAIR OR STRETCHER

If you need a car seat, wheelchair or a stretcher for your ride to a routine doctor's visit, Patient Transport Services vans can take you there and bring you back.

You must call Customer Care to set up these rides at least three to four working days before your appointment date.

IF YOU CALL TO GET A RIDE TO A MEDICAL APPOINTMENT, PLEASE BE READY TO TELL THE REPRESENTATIVE THE FOLLOWING:

- Your name, AHCCCS ID number, date of birth, address, phone number (for verification purposes).
- The date, time and address of your medical visit.
- If you need a ride one way or a round trip.
- Your travel needs (wheelchair, stretcher or other).
- Any special needs (oxygen, IVs, someone who needs to travel with you, an extra-wide or electric wheelchair, a high-top vehicle, etc.)
- Children under the age of 5 require a car seat. Let the representative know if you do not have a car seat.

CANCELING RIDES TO YOUR APPOINTMENTS

If you cancel your doctor or dentist visit, you must also call Customer Care to cancel your ride to your visit.



Urgent Care and Emergency Room Use

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

While you are out of the county or state, Maricopa Health Plan will pay for emergency care only. If you need emergency care while out of the county or state, please show your AHCCCS Identification Card to the doctor/hospital so they can call your PCP to let him or her know of your situation.

WHAT TO DO IN CASE OF AN EMERGENCY

Medical emergencies are sudden conditions, which are life or death situations. They may lead to disability or death if not treated as soon as possible. **No prior authorization is necessary for emergency care.**

If you feel your symptom is an emergency, call 911. As a member of Maricopa Health Plan you have the right to seek Emergency Service at any hospital or other Emergency Room facility (in or out of network).

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

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

TIPS ON WHEN THE EMERGENCY ROOM SHOULD NOT BE USED:

Do not go to the Emergency Room for normal health care. The Emergency Room is for emergencies only!

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

Should you go to the Emergency Room or Urgent Care?

EXAMPLES OF EMERGENCY ROOM SYMPTOMS
<p>Extreme shortness of breath Fainting Poisoning Chest pains Uncontrolled bleeding Seizures</p>
EXAMPLES OF URGENT CARE SYMPTOMS
<p>Vomiting for more than 6 hours (if young child, call PCP) Diarrhea for more than 6 hours (if young child, call PCP) Sprained ankle Minor burns and rashes A minor allergic reaction Flu, Sore throat with a fever, earaches</p>

Member Rights

Concerns or Grievances about Maricopa Health Plan

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

Maricopa Health Plan
Attn: Grievance & Appeals
Department

2701 E. Elvira Road
Tucson, AZ 85756

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

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

WHAT IF YOU HAVE QUESTIONS, PROBLEMS OR COMPLAINTS ABOUT MARICOPA HEALTH PLAN?

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

Appeal and Request for Fair Hearing

WHAT IF YOU DISAGREE WITH A DENIED SERVICE?

If you are dissatisfied with an “action” or denial of services by MHP you may file an “appeal”. An appeal must be filed in writing within 60 days from MHP’s Notice of Action letter.

WHO MAY FILE AN APPEAL?

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

WHAT CAN YOU FILE AN APPEAL FOR?

The reasons you may file an appeal are:

- Denial or limited authorization of a requested service, including the type or level of service
- Reduction, suspension, or termination of a previously authorized service
- Denial, in whole or in part, of payment for a service
- Failure to provide services in a timely manner
- Failure to act within the timeframe required for standard and expedited resolution of appeals and standard disposition of grievances
- The denial of a rural enrollee’s request to obtain services outside the contractor’s network under 42CFR 438.52 (b)(2)(ii), when the contractor is the only contractor in the rural area.

HOW DO YOU FILE AN APPEAL?

You can mail or fax the Grievance & Appeals Department or you may call and ask to speak to an Appeals

representative. Maricopa Health Plan will provide you with a written decision within 30 days of filing the appeal.

HOW DO YOU REQUEST A STATE FAIR HEARING?

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

WHAT IS AN EXPEDITED APPEAL?

You may file an expedited appeal, or it may be filed on your behalf by your provider. It will be approved if MHP determines that the time to process a standard appeal would seriously jeopardize your health, life or ability to attain, maintain or regain maximum function. If an expedited appeal request is not approved, MHP will notify you within two (2) days.

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

Yes, but the request must be in writing and be received by MHP within 10 days of the receipt of the notice of action letter. However, you may be responsible for payment of those services if MHP upholds the denial.

Member Rights and Responsibilities

OUR COMMITMENT TO YOU

Maricopa Health Plan's goal is to provide high-quality medical care and advanced medical treatment. We also promise to listen, treat you with respect, and understand your individual needs. Members have rights and responsibilities. The following is a description of your rights and responsibilities.

MEMBER RIGHTS

1. You will receive care that meets your needs in a way that doesn't judge race, gender, religious beliefs, values, language, how much a person is able to do, age, handicap, or ability to pay.
2. You will be treated with respect and dignity. We understand your need for privacy and confidentiality including protection of any information that identifies you.
3. You will be treated in a safe, supportive and smoke-free environment.
4. You have the right to information about Maricopa Health Plan's services, health care providers, admission, transfer, discharge, billing policies, and members' rights and responsibilities.
5. You have the right to choose your primary care physician within the Maricopa Health Plan network.
6. The law states that you have the right to read or get copies of your medical records at no cost to you. However, your right to access medical records may be denied if the information is psychotherapy notes, compiled for, or in a reasonable anticipation of a civil, criminal or administrative action, protected health information subject to the Federal Clinical Laboratory Improvement Amendments of 1988 or exempt pursuant to 42 CFR 493.3(a)(2).

- You have the right to have MHP amend or correct your medical records.
- You have the right to review your medical records if you are denied access to inspect or obtain a copy.

The contractor must reply to your request for medical records within thirty (30) days. This response will either be a copy of your records, or a reason for denying your request. If a request is denied, in whole or in part, the Contractor must give you a written denial within sixty (60) days that includes the reason for the denial, your rights to disagree, and your rights to include your amendment with any future disclosures of your health information.

7. You have the right to help in decision making about your health care and Advance Directives (decisions about what kind of care you would like to receive if you become unable to make medical decisions).
8. You have the right to complain to us about Maricopa Health Plan and/or care provided.
9. You have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
10. Your wishes are important. You have the right to the information needed to help you make informed decisions. Here is a list of some, but not all of your rights:
 - You can accept or refuse any treatment. You will be informed of any consequences of refusing treatment.
 - You can receive information on available treatment options and alternatives.
 - You can make Advance Directives and appoint someone to make health care decisions for you. You or your

representative can change your Advance Directives at any time.

- You or someone who represents you can take part in resolving problems about your health care decisions.
11. You have the right to the following:
 - You can be told about Physician Incentive Plans that affect referral services.
 - You have the right to know that Maricopa Health Plan is required to participate in a stop-loss insurance program.
 - You can be told the types of plans Maricopa Health Plan uses for compensation.
 - You can get a summary of member survey results.
 12. You have the right to have language interpretive services from a provider who speaks your primary language, if other than English.
 13. You have the right to have a list of available PCPs, including those who speak a language other than English.
 14. You have the right to a second opinion from a qualified health care professional within MHP's network. If an in-network second opinion is not available, you have the right to have a second opinion arranged outside of the MHP network at no cost to you.



15. You have the right to request a copy of the Notice of Privacy Practices at no cost to you. The notice describes Maricopa Health Plan's privacy practices and how we use health information about you and when we may share that health information with others.

The Living Will gives information about whether you want or don't want life sustaining procedures if you have a condition that cannot be cured or improved.

A Medical Power of Attorney allows you to name a person you trust to decide what type of treatment you will receive if you are unable to decide for yourself.

MEMBER RESPONSIBILITIES

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

Advanced Directives

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

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

What is Fraud and Abuse?

Fraud and abuse is any lie told on purpose that results in you or some other person receiving unnecessary benefits. This includes any act of fraud defined by Federal or State law.

Examples of Member Fraud and Abuse include but are not limited to:

- Lending or selling your AHCCCS Identification Card to anyone.
- Changing prescriptions written by any Maricopa Health Plan provider.
- Giving incorrect information on your AHCCCS application.

Examples of Provider Fraud and Abuse include but are not limited to:

- Use of the Medicaid system by someone who is inappropriate, unqualified, unlicensed or has lost their license.
- Providing unnecessary medical services.
- Not meeting professional standards for health care.

ABUSE BY A PROVIDER: Actions that are not wise business or medical practices and result in:

- Unnecessary costs to the program
- Payment for services that are not medically necessary
- Not meeting professional standards for health care

ABUSE BY A MEMBER:

Unnecessary costs to the program because of:

- Providing false materials or documents
- Leaving out important information

How to Report Fraud and Abuse:

If you suspect a Maricopa Health Plan provider or member of fraud and abuse, please call MHP Customer Care at 1-800-582-8686

or
AHCCCS at 1-800-962-6690 to report it.

Penalties: A person who is suspected of fraud and/or abuse of the AHCCCS system will be reported to AHCCCS. Penalties for people involved in fraud and/or abuse may be both civil and criminal.
