On July 1, 2018, Mercy Care Plan and Mercy Maricopa Integrated Care became one company. Our new name is Mercy Care. Even though our name and logo have changed, we will continue to provide the same caring service that we have for more than 30 years. Your covered benefits and provider network will also stay the same.

Inside this member handbook the health plan name still says Mercy Care Plan. However, we will have a new member handbook available on October 1, 2018. Other materials you get from us will be updated to show the new name and logo.

Our members are at the center of everything we do. If you ever have questions or need help, please call our Member Services team at 602-263-3000 or 1-800-624-3879 (TTY/TDD 711). They are available Monday through Friday from 7 a.m. to 6 p.m. You can also visit us online at www.MercyCareAZ.org.
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Introduction

Welcome to Mercy Care Plan

For more than 30 years, our members have trusted Mercy Care Plan to be there for their families. To us, you are more than a Mercy Care Plan member. You are a member of our family. Mercy Care Plan, doctors and hospitals all work together for you. “Care” is more than just a part of our name - it is a value shared by all of us.

Your Member Handbook

Please read this handbook. You can learn about:
• Your rights and responsibilities as a member
• How to get health care services
• How to get help with appointments
• Which services are covered and which are not
• Definition of terms

This handbook is also available on audiocassette, large print, CD or digital audio file (MP3) upon request from Member Services at 602-263-3000 or 1-800-624-3879 (TTY/TDD 711). We can also send you a full-page magnifier if needed. You can also read the handbook online at www.mercycareplan.com/members/mcpltc/information.

Mercy Care Plan website

Visit our website at www.mercycareplan.com. You can get updated information on Mercy Care Plan. You can search for a doctor, pharmacy, urgent care or hospital near you. To increase the font size of the website, click on the larger “A” in the top right corner of the website. To make the font smaller, click on the smaller “A” in the top right corner of the website. Our website is also compatible with common screen readers.

www.mercycareplan.com
Member Services 602-263-3000 or 1-800-624-3879 (TTY/TDD 711)
Monday - Friday, 7 a.m. to 6 p.m.
You can also access your own health information by going to our secure web portal MercyOneSource. Go to [www.mercycareplan.com](http://www.mercycareplan.com) and click on the MercyOneSource link on the top of the page. With your secure log in, you can:

- Look up the status of a claim
- Check the status of a pending authorization
- Look up your assigned primary care provider (PCP)

Our website is also linked to Medline Plus at [www.medlineplus.gov](http://www.medlineplus.gov)

- Learn about a medical problem
- Read the latest health news
- Research medications and supplements
- Look up signs of medical conditions

**Important contact information**

**Mercy Care Plan Member Services**

Representatives can answer questions about benefits, help you find a doctor, arrange rides to medical appointments and help you get health care services. Member Services is available to help you Monday through Friday, 7 a.m. to 6 p.m. at **602-263-3000** or **1-800-624-3879** (TTY/TDD 711). You can also reach Member Services at [www.mercycareplan.com](http://www.mercycareplan.com) and select “Contact Us.”
**Long Term Services and Supports (LTSS) case management**
If you need to contact your case manager prior to your next scheduled visit, call him or her directly. Your case manager's telephone number is listed on the business card that he or she left you. Call your case manager directly between the hours of 8 a.m. and 5 p.m. You should call your case manager if you have a change in diagnosis, a change in your overall wellness requiring ongoing nursing services, or if you suspect any abuse, neglect or exploitation. If you cannot get in touch with your case manager or do not know the name of your case manager, call Mercy Care Plan Member Services.

**Nurse Line**
Our nurse line is available after business hours and on the weekends to answer general medical questions. Call Mercy Care Plan Member Services at 602-263-3000 or 1-800-624-3879, and select the “speak to a nurse” option.

**Urgent care**
This is when you need care today, or within the next couple of days, but are not in danger of lasting harm or losing your life. For example:
- Bad sore throat or earache
- Flu
- Migraine headaches
- Back pain
- Medication refill or request
- Sprains

Call your doctor before going to an urgent care center. You can find an urgent care center using the “Find a Provider” tool at www.mercycareplan.com. Select your health plan, enter the city, state and ZIP code, and select “Urgent Care Facility” under Provider Type.

**Behavioral health crisis services**
You do not need a referral from your doctor for behavioral health services. Call your case manager to discuss your behavioral health service need and he/she will assist you in obtaining services. If you need a ride to an appointment, call Member Services.

If you think you might hurt yourself or someone else, call 911. You can also call our crisis line if you feel overwhelmed and it is hard to cope with stressful things in your life. Trained crisis intervention specialists are available around the clock, every day of the year to provide triage and support services.

**Mercy Care Plan behavioral health crisis line:** 1-800-876-5835

**State and national crisis lines:**
- Central Arizona: 602-222-9444, TTY: 602-274-3360
- Southern Arizona:
  - Cochise, Graham, Greenlee, La Paz, Pima, Pinal, Santa Cruz and Yuma counties: 1-866-495-6735
  - Pima County: 520-622-6000
- Veterans Crisis Line: 800-273-8255, press 1

**National crisis text line:** Text HOME to 741741, about any type of crisis. [http://www.crisistextline.org/how-it-works](http://www.crisistextline.org/how-it-works)

**National suicide prevention hotline:** 1-800-273-8255
Warm Lines: Warm Line specialists offer peer support for callers who just need to talk.

The Warm Line is a no-cost and confidential telephone service staffed by peers who have, themselves, dealt with behavioral health issues. Warm Line staff can relate to behavioral health situations because many have been through the same experiences themselves. Warm Line specialists offer peer support for callers who just need someone to talk to.

- Central Arizona: **602-347-1100**. Available 24 hours a day, seven days a week.
- Southern Arizona: **520-770-9909** (Pima County) or **1-877-770-9912** (all other southern Arizona counties). Available seven days a week from 8 a.m. to midnight.

**If you have a medical emergency, dial 911.**

**Member Advisory Council**

Mercy Care Plan has a Member Advisory Council (MAC). The council is made up of members, just like you, who are concerned about health care and want to make health care better. Members volunteer to serve at least two years. New council members may be chosen each year. Family members, member representatives, providers and advocacy groups may also be part of the council. The MAC advises Mercy Care Plan on issues that are important to members. If you are not on the council, you may still suggest changes to policies and services by calling Member Services. You may also call Member Services for more information about how to join the council.

**Culturally competent services**

You should always use providers who are in the Mercy Care Plan network. You can get covered services and be treated fairly regardless of:

- Payer source
- Ability to pay
- Ability to speak English
- Race
- Ethnicity
- Color
- National origin (to include those with limited English proficiency)
- Religion
- Age
- Mental or physical disability
- Sexual orientation
- Gender - including but not limited to, discrimination on the basis of pregnancy, sex stereotyping and gender identity

You can get quality medical services that support your personal beliefs, medical condition and background in a language you understand.

You have the right to learn about care or treatment choices available to you and the benefits and/or drawbacks of each choice. You can get this information in a way that helps your understanding and is appropriate to your medical condition. Please contact Member Services at **602-263-3000** or **1-800-624-3879** (TTY/TDD **711**).
Language and interpretation services

All Mercy Care Plan printed materials are available in an alternative formats. For access to these alternative formats, please contact Member Services at 602-263-3000 or 1-800-624-3879 (TTY/TDD 711). These materials (including the Member Handbook and Provider Directory) are provided at no cost to you. If you need information in a language other than English, please call Mercy Care Plan Member Services.

You can also get telephone interpretation or a sign language interpreter for your health care visits at no cost to you. Your primary care provider (PCP) or specialist may also call an interpreter through our interpretation line during your visit. If you need help in your language or if you have a hearing impairment, call Mercy Care Plan Member Services Monday through Friday, 7 a.m. to 6 p.m. at 602-263-3000 or 1-800-624-3879 (TTY/TDD 711).

يمكنكم الحصول أيضاً على خدمة ترجمة فورية عبر الهاتف أو مترجم لغة إشارة مجانية لمساعدتك في زيارات الرعاية الصحية. يمكن لطبيب الرعاية الأولية (PCP) أو الاتصال الخاص بك الاتصال أيضاً بمترجم فوري عن طريق خط الترجمة الفورية التابع لنا خلال زيارتك. إذا احتاجت إلى مساعدة بلغتك أو إذا كنت تعاني من إعاقة في السمع، فيرجى الاتصال بخدمات الأعضاء لدىنا مصممة للاحتياجات الخاصة، معرفة عندما 7 صباحاً وحتى الساعة 6 مساءً على الرقم 1-800-624-3879 (إذا كنت تعاني من السمع أو ضعف السمع فاتصل بالرقم 711).

www.mercycareplan.com
Member Services 602-263-3000 or 1-800-624-3879 (TTY/TDD 711)
Monday - Friday, 7 a.m. to 6 p.m.
Mercy Care Plan has many health care providers who speak languages in addition to English. Check the Provider Directory or the Mercy Care Plan website (www.mercycareplan.com) to find a doctor who speaks your language.
Nondiscrimination Notice

Southwest Catholic Health Network Corporation d/b/a Mercy Care Plan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Southwest Catholic Health Network Corporation d/b/a Mercy Care Plan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Southwest Catholic Health Network Corporation d/b/a Mercy Care Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card or 1-800-385-4104.

If you believe that Southwest Catholic Health Network Corporation d/b/a Mercy Care Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with our Civil Rights Coordinator at:

Address: Attn: Civil Rights Coordinator
4500 East Cotton Center Boulevard
Phoenix, AZ 85040

Telephone: 1-888-234-7358 (TTY 711)
Email: MedicaidCRCoordinator@mercycareplan.com

You can file a grievance in person or by mail or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

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

Multi-language Interpreter Services

**ENGLISH:** ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card or 1-800-385-4104 (TTY: 711).

**SPANISH:** ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al número que aparece en el reverso de su tarjeta de identificación o al 1-800-385-4104 (TTY: 711).

**NAVAJO:** Díí BAA AKóNíNíZIN: Díí bee yáníłti’go, saad bee áká’ánida’awo’dedé’, t’áá jik’eh, éí ná hóló. Ninaaltsoos nîtítizí bee nééhozinígii bine’dedé’ béésh bee hane’í biká’ígíí bee hodíílnihdoodago 1-800-385-4104 (TTY: 711 hólne’ dooleeł.

**CHINESE:** 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電您的ID卡背面的電話號碼或 1-800-385-4104 (TTY: 711)。

**VIETNAMESE:** CHÚ Ý: nếu bạn nói tiếng việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Hãy gọi số có ở mặt sau thẻ id của bạn hoặc 1-800-385-4104 (TTY: 711).

**ARABIC:** إذا كنت تتحدث باللغة العربية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل على الرقم الموجود خلف بطاقتك الشخصية أو عل الكرد والبكم: 1-800-385-4104.

**TAGALOG:** PAUNAWA: Kung nagsasalita ka ng wikang Tagalog, mayroon kang magagamit na mga libreng serbisyo para sa tulong sa wika. Tumawag sa numero na nasa likod ng iyong ID card o sa 1-800-385-4104 (TTY: 711).

**KOREAN:** 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 ID 카드 뒷면에 있는 번호로나 1-800-385-4104 (TTY: 711) 번으로 연락해 주십시오.

**FRENCH:** ATTENTION: si vous parlez français, des services d’aide linguistique vous sont proposés gratuitement. Appelez le numéro indiqué au verso de votre carte d’identité ou le 1-800-385-4104 (ATS: 711).


JAPANESE: 注意事項: 日本語をお話しになる方は、無料で言語サポートのサービスをご利用いただけます。IDカード裏面の電話番号、または1-800-385-4104 (TTY: 711)までご連絡ください。

PERSIAN: اگر به زبان فارسی صحبت می کنید، به صورت رایگان می توانید به خدمات کمک زبانی دسترسی داشته باشید. با شماره درج شده در پشت کارت شناسایی یا با شماره 1-800-385-4104 (TTY: 711) تماس بگیرید.

SYRIAC: حمله ى ئاسى، ىنادى مكرس، ىسدرك، مكرس، ىلعى، مكرس، ىلعى، لىش(JSON: 711) 1-800-385-4104


THAI: ข้อควรระวัง: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรีโดยติดต่อมายเลอที่อยู่ด้านหลังบัตร ID ของคุณ หรือหมายเลข 1-800-385-4104 (TTY: 711)
Your provider directory

A provider directory is a listing of Mercy Care Plan doctors and other providers of health care services. There is a searchable online provider listing on our website at www.mercycareplan.com. Select “Find a Provider” in the upper right hand corner of the screen. You can find information about Mercy Care Plan providers such as:

- Primary Care Providers (PCPs)
- Specialists
- Hospitals
- Nursing facilities
- Pharmacies
- Assisted Living Facilities
- Urgent Care Centers

You can narrow your search by ZIP code, city or county. Provider information includes addresses, phone numbers, languages spoken and whether a provider is accepting new members. The provider directory has information identifying provider offices that accommodate members with physical disabilities.

You can contact Mercy Care Plan Member Services for a paper copy of the provider directory. You can also ask your case manager for a paper provider directory. This will not cost you anything.

About Mercy Care Plan

Mercy Care Plan (MCP) is a contracted health plan with the Arizona Health Care Cost Containment System (AHCCCS). AHCCCS is Arizona’s Medicaid agency. Mercy Care Plan serves Long Term Services and Supports (LTSS) members in Pima, Pinal, Gila and Maricopa counties. Contract services are funded under contract with the State of Arizona. Mercy Care Plan follows federal and state laws that apply under the contract with AHCCCS. Mercy Care Plan is a managed care health plan. As a managed care health plan, we provide health care to our members through a select group of doctors, hospitals and pharmacies. This is called a provider network. You will need to go to the doctors and providers who are part of our provider network so that you don’t have to pay for services yourself.
About our providers

A primary care provider (PCP) is a doctor who will coordinate most of your care. Some PCPs are family and internal medicine doctors, pediatricians, and OB/GYNs. You will see your PCP for routine and preventive care. Your primary care provider is the “gatekeeper” for medical services. The PCP will evaluate your health during your visit and determine if you need to see a specialist or have tests performed.

Your health care is important to us. Mercy Care Plan chooses the doctors and other providers in our network very carefully. They must meet strict requirements to care for our members, and we regularly check the care they give you. If you need more information about your doctor, you may contact the organizations in the following table.

<table>
<thead>
<tr>
<th>NAME OF ORGANIZATION</th>
<th>TELEPHONE NUMBER</th>
<th>WEBSITE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arizona Medical Association</td>
<td>1-800-482-3480</td>
<td><a href="http://www.azmed.org">www.azmed.org</a></td>
</tr>
<tr>
<td>Arizona Medical Board</td>
<td>480-551-2700 or 1-877-255-2212</td>
<td><a href="http://www.azmd.gov">www.azmd.gov</a></td>
</tr>
<tr>
<td>American Board of Medical Specialties</td>
<td>1-866-275-2267</td>
<td><a href="http://www.abms.org">www.abms.org</a></td>
</tr>
<tr>
<td>Arizona State Board of Dental Examiners</td>
<td>602-242-1492</td>
<td><a href="http://www.dentalboard.az.gov">www.dentalboard.az.gov</a></td>
</tr>
<tr>
<td>Arizona Board of Osteopathic Examiners</td>
<td>480-657-7703</td>
<td><a href="http://www.azdo.gov">www.azdo.gov</a></td>
</tr>
<tr>
<td>Arizona State Board of Optometry</td>
<td>602-542-3095</td>
<td><a href="http://www.optometry.az.gov">www.optometry.az.gov</a></td>
</tr>
</tbody>
</table>

Member identification (ID) card

When you become a member of Mercy Care Plan, Mercy Care Plan will send you a new ID card. Be sure to carry your ID card with you and show it every time you get health care services. If you do not get your ID card or if you lose it, call Mercy Care Plan Member Services.

• Your ID card will have your name, ID number and the name of your health plan - Mercy Care Plan.
• Your ID card has a phone number to access behavioral health and substance abuse services. Services are assigned to a provider based on where you live. If you have questions or need help getting behavioral health services, please call the number on your card.
• If you have an Arizona driver’s license or state issued ID, AHCCCS will get your picture from the Arizona Department of Transportation Motor Vehicle Division (MVD). When providers pull up the AHCCCS eligibility verification screen, they will see your picture (if available) with your coverage details.
• Protect your ID card. Do not give it to anyone except those giving health care services to you. Keep your ID card. Do not throw it away. If you loan, sell or give your ID card to anyone else, you may lose your ALTCS eligibility and/or legal action may be taken.
• If you lose your card, call Member Services and ask for a new card.
• If you do not get your ID card, call Mercy Care Plan Member Services at 602-263-3000 or 1-800-624-3837 (TTY/TDD 711).
YOUR RESPONSIBILITIES AS A MEMBER

As a member, you, your family or your guardian(s) have the following responsibilities:

RESPECT
• Respect the doctors, pharmacists, staff and people providing services to you.
• Protect your ID card. Do not lose it or share it with anyone.
• Take care of equipment loaned to you such as wheelchairs and the possessions belonging to the place where you live.
• Be considerate of the rights of staff and others who are living in the same place as you.
• Be respectful of their property.

SHARE INFORMATION
• Show your member ID card, or identify yourself as a Mercy Care Plan member, to health care providers before getting services. If you have additional insurance, in addition to Mercy Care Plan, show your doctor or pharmacist your other insurance ID card.
• If you do not understand your health condition or treatment plan, ask your PCP to explain.
• Tell your doctor and/or case manager about insurance that you have. Apply for benefits for which you may be eligible through your additional insurance.
• Give your doctor all the facts about your health problems. This includes past illnesses, hospital stays, all medications, shots and other health concerns. Let your doctor and/or your case manager know about any changes in your health condition.
• Notify Mercy Care Plan any time you feel a provider or another member is not using health plan benefits correctly.
• Report changes that could affect your eligibility such as family size, address, phone number and/or assets to your case manager and/or to the office where you applied for AHCCCS eligibility.

FOLLOW INSTRUCTIONS
• Know the name of your assigned PCP and your case manager.
• Follow the treatment instructions that you and your PCP have agreed on, including the instructions from nurses and other health care professionals.
• Pay your share of cost and/or room and board at the start of every month.

APPOINTMENTS: PROVIDERS INCLUDING DENTISTS
• Schedule appointments during office hours (instead of using urgent or emergency care).
• Keep appointments. Go to your appointments on time. Call your doctor’s office ahead of time when you cannot keep your appointment.
Reporting changes in family size or address

Changes in family size
You must report all changes in your family, like births and deaths, to the agency that determined your eligibility. Newborns are put on your insurance only if you tell this agency. For more information, please call AHCCCS Eligibility Verification at 602-417-7000 or 1-800-331-5090.

Change of address/Out-of-area moves
Mercy Care Plan and Arizona Long Term Care System (ALTCS) need your correct address. If we do not have your correct address, you may not get important information from us.

If you are moving, call your case manager with your new address before you move. Let the ALTCS office where you applied for ALTCS know of your move.

Mercy Care Plan serves Long Term Services and Supports (LTSS) members in Pima, Pinal, Gila and Maricopa counties. If you plan to move to a new county, other than Pima, Pinal, Gila or Maricopa counties, or to an Indian Reservation, call your case manager. They can arrange and coordinate your care and services with the program contractor in your new county. If you do not let your case manager know, you may not get the services you need.

Annual Enrollment Choice (AEC)
Mercy Care Plan is your health plan. Annual Enrollment Choice (AEC) is the time during the year when you may choose a new health plan if you want. ALTCS will send you information about health plans in your area before your AEC time. You can look through it and decide whether you want to change or not. Before you decide to change, please call your case manager or Member Services. We may be able to help you with any problems you might be having.

Health plan changes
You may change health plans for any reason once a year on the date you first became an AHCCCS member or ALTCS eligible.

You may also request a change at any time if any of the following is true:
1. For cause at any time. Causes include poor quality of care, unable to received medically-necessary covered services or unable to access a provider who knows how to address your care needs.
2. Without cause 90 days after your initial enrollment, or during the 90 days of your notification of enrollment, whichever is later.
3. Without cause if you missed your annual disenrollment period because you were temporarily disenrolled.
4. You were not given a choice when you first joined.
5. You did not get your AEC letter so you could choose.
6. You got your AEC letter, but were not able to take part in your AEC due to things out of your control.
7. Other members of your family are enrolled with another health plan.
8. You were given wrong information about available choices, or there was an error on the part of AHCCCS or Mercy Care Plan.
9. You move to your own home in another county other than Pima, Pinal, Gila or Maricopa County.
10. You re-enrolled in ALTCS within 90 days and were not re-enrolled with the same health plan.
11. You are pregnant or have a complex medical condition and need to stay with your doctor who is not a Mercy Care Plan doctor. If you need to change your doctor, please call Mercy Care Plan Member Services to ensure continuity of care.
Some changes need approval from the new health plan before you can change. An example of a change needing approval is if you move to a nursing home or assisted living home in another county.

**Be sure to call your case manager before you make any changes.**

**Transitional program**
This program is only for members who have improved to the point where they do not need institutional care but who still need many long-term-care services and supports. This program is not available to new members. Home-and-community-based placements are arranged for these members.

Members in the transitional program may not remain in a skilled nursing home longer than 90 consecutive days.

ALTCS eligibility workers place members on and take them off the transitional program after evaluating the member’s current functional and medical status.

**Transition of care policy**
If you change to another health plan, Mercy Care Plan will let you know the name of the new health plan, how to contact them and their emergency phone number. Mercy Care Plan will give you information about services and how to get them. We will also let the new health plan know of your special needs.
## Information about services

### Types of care

There are three different kinds of care you can get: Routine, Urgent and Emergency.

The chart below gives you examples of each type of care and tells you what to do. Always check with your doctor if you have questions about your care.

<table>
<thead>
<tr>
<th>Type of care</th>
<th>What to do</th>
</tr>
</thead>
</table>
| **Routine** - This is regular care to keep you healthy. For example:  
  • Checkups (also known as wellness exams)  
  • Health conditions you have had for a long time such as asthma, COPD and diabetes  
  • Yearly exams  
  • Immunizations | Call your doctor to make an appointment for preventive care. You can expect to be seen by:  
  • Your PCP within 21 days  
  • A specialist or dentist within 45 days |
| **Urgent/sick visit** - This is when you need care today, or within the next couple of days, but are not in danger of lasting harm or losing your life. For example:  
  • Bad sore throat or earache  
  • Flu  
  • Migraine headaches  
  • Back pain  
  • Medication refill or request  
  • Sprains | Call your doctor before going to an urgent care center.  
  Look in your Provider Directory to find the center closest to you or look on the Mercy Care Plan website at [www.mercycareplan.com](http://www.mercycareplan.com).  
  You can expect to be seen by:  
  • Your PCP within two (2) days  
  • A specialist or dentist within three (3) days  
  If it is late at night or on the weekends, your doctor has an answering service that will get your message to your doctor. Your doctor will call you back and tell you what to do. You should NOT go to the emergency room for urgent/sick care. |
<table>
<thead>
<tr>
<th>Type of care</th>
<th>What to do</th>
</tr>
</thead>
</table>
| Emergency - This is when you have a serious medical condition and are in danger of lasting harm or the loss of your life. For example:  
  - Poisoning  
  - Deep cuts  
  - Overdose  
  - Broken bones  
  - Car accident  
  - Serious burns  
  - A cut that may need stitches  
  - Trouble breathing  
  - Sudden chest pains- heart attack  
  - Convulsions (seizures)  
  - Very bad bleeding, especially if you are pregnant  
  - Signs of stroke (numbness/weakness in face, arm, or leg, trouble seeing with one or both eyes) | Call 911 or go to the nearest emergency room. You do not have to call your doctor or Mercy Care Plan first.  
You do not need prior authorization to call 911. If you can, show them your Mercy Care Plan ID card and ask them to call your doctor. |
| In an emergency situation, a qualified emergency room will provide services that evaluate your condition. You will also get medical treatment to help stabilize you. This may include admission into a hospital. | |

**What is not an emergency?**
Some medical conditions that are NOT usually emergencies include:

- Flu, colds, sore throats, earaches
- Urinary tract infections
- Prescription refills or requests
- Health conditions that you have had for a long time
- Back pain
- Migraine headaches

<table>
<thead>
<tr>
<th>Getting care after business hours</th>
</tr>
</thead>
</table>
| Except in an emergency, if you or your child get sick when the doctor's office is closed or on a weekend, you should still call the office. An answering service will make sure your doctor gets your message. Your PCP will call you back and tell you what to do. Be sure your phone accepts blocked calls. Otherwise, the doctor may not be able to reach you.  
You can even call your PCP in the middle of the night. You most likely will have to leave a message with the answering service. It may take a while for them to get back to you, but a doctor will call you back to tell you what to do.  
To find the urgent care center closest to you, you can look on the Mercy Care Plan website at [www.mercycareplan.com/findaprovider](http://www.mercycareplan.com/findaprovider). You can also look in the Mercy Care Plan Provider Directory. |

www.mercycareplan.com
Member Services 602-263-3000 or 1-800-624-3879 (TTY/TDD 711)  
Monday - Friday, 7 a.m. to 6 p.m.
If you need sick care in the evening or on weekends, you can get care at Walgreens Healthcare Clinics in Phoenix and Tucson.

- To find the Walgreens Healthcare Clinic nearest you, visit www.walgreens.com/pharmacy/healthcare-clinic/locations.jsp.
- You can also search for these locations via www.mercycareplan.com/findaprovider.

YOU SHOULD NOT GO TO THE EMERGENCY ROOM FOR URGENT/SICK CARE.

Out-of-area coverage

Mercy Care Plan provides ALTCS services in Maricopa, Pinal, Gila and Pima counties. NO services are covered outside the United States.

If you move outside of Arizona, you need to close your eligibility file in Arizona. Call your eligibility office as soon as possible and tell them when you move to another county or state. When you move to a new state, sign up for the state medical program. If you move out of the United States, your AHCCCS eligibility will end. If you have a new address, report it to the office that helped you with your eligibility. If you have an emergency while away, go to the closest emergency room and follow these steps:

- Show your member ID card to the hospital.
- Tell them you are a Mercy Care Plan member.
- Ask the hospital to send the bill to Mercy Care Plan for payment.
- Do not pay the bill yourself.

Follow-up/routine care not related to an emergency is not covered while you are away. This includes prescriptions. You should get follow-up care from your PCP. Mercy Care Plan may approve health care services that are not available where you live. If this happens, we may pay for transportation, lodging and food costs. Mercy Care Plan will only pay for these services if they approve these first (before you receive these services.) Please call Mercy Care Plan Member Services before your trip to help make your arrangements.

Transportation services (rides)

If necessary, Mercy Care Plan can help you get to your AHCCCS-covered health care visits. If you live in a nursing home or assisted living facility, staff will arrange a ride for you and, if needed, an ambulance.

If you live at home or in another community setting, it is important for you to find out first if a relative, friend or neighbor can give you a ride. If you can ride the bus, we will send you bus tickets or passes at no cost to you.

How to get a ride

Please call Member Services at least three (3) business days before your appointment to get a ride. If you call the same day, we may not be able to arrange a ride for you in time, unless it is urgent. You may have to reschedule your appointment.

If you have many appointments scheduled, or if you have regular appointments for visits like dialysis, please call Member Services to set up all rides at one time.

After your appointment, call your transportation provider to arrange a pick-up time.
Tips for getting a ride

<table>
<thead>
<tr>
<th>Things to do</th>
<th>Things not to do</th>
</tr>
</thead>
<tbody>
<tr>
<td>• DO call Mercy Care Plan Member Services as soon as you make your appointment.</td>
<td>• DO NOT be late for your pick-up time.</td>
</tr>
<tr>
<td>• DO call Mercy Care Plan at least three (3) hours before an appointment that you made on the same day for urgent care.</td>
<td>• DO NOT forget to call Mercy Care Plan to cancel your ride if you find another one or if you change your appointment.</td>
</tr>
<tr>
<td>• DO let us know if you have special needs, like a wheelchair or oxygen.</td>
<td>• DO NOT wait until the day of your appointment to call for a ride.</td>
</tr>
<tr>
<td>• DO make sure your prescription is ready for pick up before calling for a ride.</td>
<td></td>
</tr>
<tr>
<td>• DO NOT schedule a ride if you are not going to be at your pick-up place.</td>
<td></td>
</tr>
</tbody>
</table>

If you have a medical emergency, dial 911. Use of emergency transportation must be for emergencies only.

If you need a ride to your appointment, call Mercy Care Plan Member Services at 602-263-3000 or 1-800-624-3879 (TTY/TDD 711).

Smartphones at no cost to you

Mercy Care Plan members can get a smartphone at no cost to you. This program is called Lifeline. You can apply for this service at www.LifelineApply.com/mercycareplan. You must provide proof of income or proof that you are a Mercy Care Plan member as part of your application.

If you qualify, you’ll receive an Android smartphone that includes 500 MB of data each month or 500 voice minutes. You’ll also receive unlimited text messages and no-cost text message health tips and education.

This program provides one smartphone per household. Calls to Mercy Care Plan Member Services do not count toward your voice minutes.

If you already have a smartphone, you can add the no-cost data, voice minutes and unlimited texting. If you want to change your cell phone to a smartphone, you can do that through this program. To apply, visit www.LifelineApply.com/mercycareplan and choose the “Bring Your Own Device” option.

For more information, call Mercy Care Plan Member Services at 602-263-3000 or 1-800-624-3879 (TTY/TDD 711).

Case management services

When you become a member of Mercy Care Plan Long Term Care, you are assigned a case manager. You will continue to receive case management services for as long as you remain on the ALTCS program. Your case manager will work with you, your guardian or designee, and your PCP to assess your needs. Your case manager will partner with you and your family/representative to develop your plan of care.

If you live in your own home or in an alternative residential setting, your case manager will visit you face-to-face every three (3) months. If you live in a nursing home, your case manager will visit you face-to-face every six (6) months.
At each visit, your case manager will complete “Assessment Tools.” These tools help us learn more about you. Your case manager will ask about your strengths, what you can do to take care of yourself, and areas in which you need help. The case manager will work with you and your family to help decide which services will best meet your needs.

You should contact your case manager if you:
• Move
• Change your phone number
• Go into the hospital
• Need more help
• Your caregiver does not show up as scheduled

You can contact your case manager by calling the number on the business card he/she gave to you.

If you do not know:
• Your case manager's name, or
• How to contact your case manager between scheduled visits, then call Mercy Care Plan Member Services. They will be able to help you.

Mercy Care Plan staff can help manage your health care by working with you, community and state agencies, schools, and your doctor to get you all of the covered services you need.

Long Term Services and Supports (LTSS) covered medical services and benefits

Your PCP and case manager will help you get the health care and long term services and supports you need. Below is a list of covered services. There may be some limitations based on AHCCCS rules and policies. If you have Medicare, read the Medicare handbook called “Other Things You Should Know About Medicare” to find out which services are covered.

*Covered services are provided in medical offices, hospitals and pharmacies. Your provider will let know where to access services.

Long term services and supports
1. Nursing home care
2. Home and community based services
   • Adult day health care
   • Attendant care (includes spouse attendant care and self-directed attendant care)
   • Community transitional service
   • Emergency alert system
   • End of life care
   • Habilitation (includes day treatment and training)
   • Home-delivered meals
   • Home health services
   • Homemaker services
   • Home modifications
   • Hospice
   • Personal care services
   • Private duty nursing
   • Respite and group respite care
   • Supportive employment
3. Alternative residential settings
   • Adult foster care
   • Adult developmental home
   • Assisted living home
   • Assisted living center
   • Behavioral health facility
   • Child developmental certified home
   • Substance abuse transitional facility
   • Therapeutic home care - adult and child
   • Traumatic brain injury home

Medical Services
• Hospital care, including inpatient medical care, observation and outpatient medical care
• Routine immunizations, such as flu shots
• Diabetes care, including A1C screenings and eye exams for diabetes-related care
• Doctor office visits, including specialists and primary care providers
• Health risk assessments and screenings, such as blood pressure testing, mammography and colon cancer screenings
• Nutritional assessments, including evaluation and dietary recommendations
• Laboratory and x-rays, including blood work
• Durable medical equipment such as crutches, walkers, wheelchairs and blood glucose monitors
• Medical supplies such as catheters and oxygen
• Medications on Mercy Care Plan’s list of covered medicines - members with Medicare will receive their medications from Medicare Part D
• Emergency medical care - when you have a serious medical condition and are in danger of lasting harm or the loss of your life
• Care to stabilize you after an emergency
• Rehabilitation services, including occupational, speech, physical and respiratory therapy (limitations apply)
• Kidney dialysis
• Maternity care (prenatal, labor and delivery, postpartum)
• Family planning services such as contraceptives and testing for sexually transmitted infections
• Behavioral health services and settings
• Medically necessary transportation to and from required medical services; emergency transportation
• Outpatient surgery and anesthesia
• Audiology services, including evaluation and treatment of hearing loss
• Medical foods, with limitations
• Urgent care services - when you need care today, or within the next couple of days
• Limited vision services, for members 21 years of age or older, including: emergency eye care and some medically necessary vision services, such as cataract removal. Members with diabetes should see an ophthalmologist yearly for a retinal exam
• Limited dental services for members 21 years of age or older
• Treatment of sexually transmitted diseases
• Incontinence briefs to avoid or prevent skin breakdown, with limitations
• Wellness exams and preventive screenings
• Foot and ankle services such as treatment for foot pain or preventive diabetic foot care
• Orthotics to support or brace weak joints or muscles
• Breast reconstruction after a mastectomy
• Prescriptive lenses after cataract surgery
Additional services for children (under age 21)

- Dental homes for members under 21 years of age. A “dental home” is an office or facility where all dental services are provided in one location. This is a place where you (if under 21 years of age) and your children can build a relationship with your dental provider and get all of your dental needs met. All members under 21 years of age are assigned to a dental home. You can call Member Services to help you with the following activities:
  - Find out the name, address and telephone number of your dental home or your child's dental home
  - Change/find a new dental home provider
  - Help you make your appointment or your child's appointment, or arrange transportation to or from the appointment
  - If you need to change or cancel your appointment, or your child's appointment, please call your dental provider 24-48 hours in advance.
- Two (2) routine and preventive dental visits are covered per year for members under the age of 21.
- Visits to the dentist must take place within six (6) months and one (1) day after the previous visit. Your child should have his or her first dental visit by 1 year of age. You do not need a dental care referral for members under 21 years of age. Services include: oral health screenings, cleanings, fluoride treatments, dental sealants, oral hygiene education, x-rays, fillings, extractions and other medically necessary procedures and therapeutic and emergency dental services.
- Routine and emergency vision services are covered for members under 21. You do not need a referral from your child's PCP to get vision services. Vision services include exams and prescriptive lenses.
- EPSDT visits (same as wellness visits) includes checkups and immunizations (shots). See section on EPSDT/Children's Services.
- Chiropractic services
- Conscious sedation
- Incontinence briefs, with limitations
- Additional services for Qualified Medicare Beneficiaries (QMBs)
- Any service covered by Medicare but not by AHCCCS

Experimental services and treatments

Mercy Care Plan and AHCCCS work together to look at new medical procedures and services to make sure you get safe, up to date, high quality medical care. A team of doctors reviews new health care methods to decide if they should become covered services. **Experimental services and treatments that are being researched and studied are not covered services.**

To decide if new technology will be a covered service, Mercy Care Plan and AHCCCS:
- Study the purpose of each technology
- Review medical literature
- Determine the impact of a new technology
- Develop guidelines on how and when to use the technology
### Limited and excluded benefits/services: for members 21 years or older

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

<table>
<thead>
<tr>
<th>BENEFIT/SERVICE</th>
<th>SERVICE DESCRIPTION</th>
<th>SERVICE EXCLUSIONS OR LIMITATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractic services</td>
<td>Hands on therapy for spinal manipulation or adjustment.</td>
<td>Excluded except for QMB members.</td>
</tr>
<tr>
<td>Bone-anchored hearing aid</td>
<td>A hearing aid that is put on a person's bone near the ear by surgery. This is to carry sound.</td>
<td>AHCCCS will not pay for Bone-Anchored Hearing AID (BAHA). Supplies, equipment maintenance (care if the hearing aid) and repair of any parts will be paid for.</td>
</tr>
<tr>
<td>Cochlear implant</td>
<td>A small device that is put in a person's ear by surgery to help him/her hear better.</td>
<td>AHCCCS will not pay for cochlear implants. Supplies, equipment maintenance (care of the implant) and repair of any parts will be paid for.</td>
</tr>
<tr>
<td>Lower limb microprocessor controlled joint/ prosthetic</td>
<td>A device that replaces a missing part of the body and uses a computer to help with the moving of the joint.</td>
<td>AHCCCS will not pay for a lower limb (leg, knee or foot) prosthetic that includes a microprocessor (computer chip) that controls the joint.</td>
</tr>
<tr>
<td>Transplants</td>
<td>A transplant is defined as the transfer of an organ or blood cells from one person to another.</td>
<td>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.</td>
</tr>
<tr>
<td>Physical therapy</td>
<td>Exercises taught or provided by a physical therapist to make you stronger or help improve movement.</td>
<td>Coverage for out-patient physical therapy visits is limited to 15 visits to re-learn a skill and 15 visits to learn a new skill per contract year (October 1 – September 30). Coverage for members who have Medicare is limited to payment of copays for 15 visits. Members who have Medicare should contact the health plan for help in determining coverage.</td>
</tr>
</tbody>
</table>
### Critical care services

Critical care services: tasks such as bathing, toileting, dressing, feeding, transferring to or from bed or wheelchair, and assistance with similar daily activities.

You and your case manager will complete a back-up plan for you if you receive critical care services. The plan will list the names and phone numbers of people and agencies to call when your caregiver does not come as scheduled. You must choose how soon you need someone to come to your home to help you.

If your caregiver does not come as scheduled, call the phone numbers on your back up plan for help. You have the right to have another caregiver help you within two (2) hours following your request for help.

### Home and community based services

Home and community based services support you in keeping your independence and living in your own home or a community setting. Your case manager will work with you, your family or guardian, and your PCP to find the right kinds of services and amount and length of those services that are just right for you. These are based on AHCCCS rules and policies. Not all services will be right for you. Once these services are decided, your case manager will approve and arrange them for you.

- **Adult day health care** - health care and supervision that you get in an adult day center. Meals, health checks and therapies may also be offered.
- **Attendant care services** - a trained person from a caregiver agency comes into your home to help you with a combination of services such as personal care, housekeeping and meal preparation.
- **Community transition program** - this service provides financial assistance to members moving from a nursing home to a home in the community. Ask your case manager to explain the AHCCCS rules for this service.
- **Emergency alert system** - equipment that allows you 24 hour access to emergency help when you need it.
- **Habilitation** - this service provides training in independent living skills. Speech, occupational or physical therapy may be provided as part of this service. This includes habilitation services such as day treatment and training and supportive employment.
- **Home-delivered meals** - healthy meals are prepared and brought to your home.
- **Home health service** - this service provides part time care in your home to prevent you from being hospitalized again. It may include nursing care, a health aide, equipment or therapy.
- **Homemaker** - this service helps with household jobs like cleaning, shopping or washing clothes.
• **Home modification** - this service makes adaptive changes to your home to increase your independence.

• **Hospice care** - services that help members who need health care and emotional support during the final stages of life.

• **Housing subsidy** - this service provides vouchers for housing to members with an SMI designation who would otherwise be homeless.

• **Personal care** - this service offers help with eating, bathing and dressing.

• **Private duty nursing** - nursing services for members who need more individual and continuous care.

• **Respite** - this service provides care to give your family member or other caregiver a rest. This service can be provided in your home, assisted living facility or skilled nursing home.

• **Spouse attendant care** - attendant care services provided by the member's spouse. State guidelines must be followed. Speak to your case manager if you are interested in this service.

**Member-directed care options**

Member-directed options allow members to have more control over how certain services are provided, including services like attendant care, personal care and housekeeping. The models are not a service, but rather define the way in which services are delivered. Member-directed options are available to most Arizona Long Term Care System (ALTCS) members who live in their own home. The options are not available to members who live in an alternative residential setting or nursing facility. ALTCS members or their representatives are encouraged to contact their case manager to learn more about and consider member-directed options:

• **Self-directed attendant care (SDAC)** - SDAC is one of the three available service delivery options for ALTCS members who receive attendant care services in their own home. Under SDAC, members will hire/fire, train, and be in charge of his or her own caregivers. Members have more control and responsibilities in this service delivery option. They can hire anyone that has the basic skills needed, give work, and make schedules within the weekly hours, which are determined by meeting with the case manager.

• **Skilled self-directed attendant care** - this option is for members that have a self directed attendant and want this attendant to be trained on specific skilled services such as bowel care or giving insulin shots. Your case manager can tell you the skilled services that are included in this program.

• **Agency with Choice** - Under Agency with Choice, members play an active role in directing their care with support from a provider agency. Agency with Choice is one of three available service delivery options for ALTCS members who receive attendant care, personal care, habilitation, and/or homemaker services in their own home.

**Alternative living settings**

Besides your own home, ALTCS offers other types of living arrangements for members. These types of settings provide supervisory services, personal care or directed care, and are licensed or certified. Members are required to pay a Room and Board fee for these settings. Your case manager will let you know what you need to pay.

• **Adult foster care** - this family setting (for up to four (4) residents) provides special care for you in a family setting.

• **Assisted living home** - this setting provides care and supervision for up to 10 people.

• **Assisted living center** - this setting provides apartments and includes private sleeping, kitchen and bathroom areas.

• **Behavioral health residential facility** - this setting provides behavioral health treatment with 24 hour supervision. They may include on site medical services and intensive behavioral health treatment programs.

• **Therapeutic home care (adult & child)** - Adult: provides behavioral health and additional services for at least one and up to three people. Child: licensed by Department of Economic Security (DES) as a professional foster care home.
• **Traumatic brain injury treatment facility** - this setting provides treatment and services for people with traumatic brain injuries.
• **Substance abuse transitional facility** - this setting provides behavioral health services.

## Nursing home care

Nursing homes provide room, board and nursing services for members who need these services all the time, but who do not need to be in a hospital or need daily care from a doctor. Many nursing homes also offer special services or different levels of care for special needs.

## End of life care

End of life care (EOL) involves all health care and support services provided to you at any age or stage of your illness. It focuses on a person-centered approach to comfort and quality of life while protecting your rights and dignity. With end of life care, you and your family will receive information about your illness that helps you understand and make decisions about your care. If you choose to do so, your case manager will help you and your family access services that are included in EOL care. These services include advance care planning, curative care, supportive care, palliative care, and hospice.

Advance care planning is a voluntary face-to-face discussion between you, your family and your doctor or medical provider. You may want to discuss your illness, health care options, social needs, psychological needs and spiritual needs. Your doctor or medical provider can work with you and your family to develop a plan of care that includes your choices for care and treatment. Your choices can be shared with your family, friends or other providers according to your wishes. Your doctor or provider can also help you with advance directives.

Curative care provides medical treatment and/or therapies in order to improve or eliminate symptoms that you are experiencing and to cure overall medical problems. You can choose to receive curative care until you choose to receive hospice care.

Supportive care is psychological, social, spiritual and practical support to improve your comfort and quality of life. Supportive care may be arranged by your case manager. Supportive care may also be provided by friends, family or services available in the community.

Palliative care is a service that works closely with your doctor or medical provider to provide relief from the pain, symptoms and the stress of a serious illness.

Hospice care consists of health care and emotional support for a person with a terminal illness who is approaching the end of their life. Hospice services provide comfort and support, but do not focus on curing your illness. Members under the age of 21 may receive curative care at the same time as hospice care.

## Referrals

Your PCP may refer you to other providers to get special services. When your PCP asks you to see a specialist for a specific problem this is a “referral.” A referral can also be made for additional services performed at a lab, hospitals, etc.

Mercy Care Plan may need to review and approve certain referrals and special services before you can get the services. Your PCP will know when to get Mercy Care Plan’s approval. If your referral needs approval by Mercy Care Plan, your PCP will let you know the status of the referral.
Self-referral
You do not need a referral from your PCP for the following services:
• Dental and vision, if you are under 21 years of age
• OB/GYN covered services
• Behavioral health services (refer to the section on Behavioral Health for a listing of covered services)
• Most home and community based services

Family planning services are administered by Aetna Medicaid Administrators, LLC. Talk to your PCP if you need help with family planning services. These services are covered at no cost to you and are available to male and female members of reproductive ages. You are not required to obtain a referral before choosing a family planning provider.

You may seek family planning services without your PCP’s approval by doing the following:
1. Make an appointment with the provider. The provider can be any provider of medical services, such as a primary care physician, nurse practitioner, etc. The provider can be in the Mercy Care Plan network, or they don’t have to be. You do not need a referral for family planning services.
2. When you make the appointment, tell the office you want to talk about getting family planning services and/or supplies.
3. Keep the appointment. Show the provider your Mercy Care Plan member ID card.
4. At the appointment, talk about your options for family planning services or supplies.
5. You will not be billed for the visit and you do not have to pay a co-pay. If you are asked to pay a co-pay or billed for the visit, please call Member Services at 602-263-3000 or 1-800-624-3879 (TTY/TDD 711) right away.
6. Your provider will tell you how to get the supplies you need. Follow their instructions to get them and to use them.

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

How your primary care provider (PCP) helps you get services
When you sign up for Mercy Care Plan, you are asked to select a primary care provider from Mercy Care Plan’s Provider Directory. Select a doctor in the area close to your home. If you do not select a PCP, Mercy Care will select one for you. The name of your PCP can be found in your welcome letter.

If you live in a nursing home, a doctor from Mercy Care Plan’s network will come to where you live and see and care for you. If you live in a nursing home, the staff will tell you of your PCP visit. They will call your doctor if there are any changes in your health.

In some cases, when medically necessary, your PCP may visit you in your own home or alternative residential setting. If you live at home or in an alternative residential setting, you, your family, guardian or caregiver can call your PCP to make or change an appointment.

We hope that you will stay with your assigned PCP so that you can work with someone who you know and knows you well. If you want to change doctors, we encourage you to talk with your PCP and case manager first and let them know why you would like to change. You may be able to work together to solve your problem or they may be able to suggest another provider for you. We do understand that you may wish to change doctors for reasons such as:
• You and your doctor don’t seem to understand each other
• You aren’t comfortable talking with your doctor openly
• Your doctor’s office is too far from home
If you need or want to change your PCP, you should contact Mercy Care Plan Member Services. They will help you make the change. The change will be effective on the first day of the month AFTER you call.

Call Mercy Care Plan Member Services at 602-263-3000 or 1-800-624-3879 (TTY/TDD 711).

You will get a letter in the mail to let you know the name and address of your new doctor. If you request three (3) or more PCP changes while you are with Mercy Care Plan, our Member Services representatives will try and work with you and your doctor before making another change.

You will need to schedule a visit with your assigned PCP soon after enrollment. You will want to start a relationship with him/her. Your PCP can screen you to find out your health care needs. When you contact your doctor's office to make your appointment, ask the following questions. These questions will help prepare you for future visits.

Questions to ask when making your PCP office visit
You can write the answers here, if you choose, so they are handy when you need them.

- What are your office hours? ______________________________________

- Do you see patients on the weekends or at night? ______________________________________

- Will you talk to me about my problems over the phone? ______________________________________

- Is there anyone else that works with you that can help me if you are not available? ______________________________________

- Who should I contact if you are closed and I have an urgent situation? ______________________________________

- How long do I have to wait for an appointment? ______________________________________

If you cannot make it to your appointment, please call your PCP's office before the appointment time to cancel.

If you are going to your PCP or dentist for the first time, please arrive at least 15 minutes early. They will need to get your information to start your health record. Show your member ID card to the office staff as soon as you arrive and before the doctor sees you. If you do not have your ID card, your doctor will still see you. You may need to show a current picture ID. Ask the office to call Mercy Care Plan for more information.

Your PCP may have to spend extra time with another patient or may have an emergency that puts him/her behind schedule. When this happens, you may have to wait a little longer to be seen. If you usually have to wait more than 45 minutes for scheduled appointments, please notify Mercy Care Plan Member Services.

Quick tips about appointments
- If you are seeing your PCP for the first time, call your PCP's office first to make sure they are accepting new patients and to verify their address.
- Call your PCP early in the day to make an appointment.
- Tell the staff person your symptoms.
- Take your member ID card with you.
- If you are a new patient, arrive at your appointment 15 minutes early.
- Let the office know when you arrive and show them your ID card.

Make the most of your doctor's visit
When visiting with your doctor, consider asking the following questions. It may help you better understand your health.
Start, stop and continue:
• Stop: What do I need to stop doing?
• Start: What do I need to start doing?
• Continue: What do I need to keep doing?

Ask your doctor these questions before you leave the office:
• What medications do I need to take (and/or stop taking)?
• When is my next appointment?
• What else do I need to know?
• What do I need to do to get better?
• What foods should I eat?
• What foods should I stop eating?
• Are there any community resources that can help me?
• Why is it important for me to follow these directions?
• What’s next? How do I get ready for my next appointment?

Patient-centered medical home (PCMH)
For many people, getting their health care needs or their family member's needs taken care of can be hard to manage. This can be especially difficult when you are helping a close family member. Mercy Care Plan understands this and offers a type of access to care that might be right for you.

Mercy Care Plan provides a way to deliver and coordinate your health care through providers who use the patient-centered medical home (PCMH) care model. This model focuses on you working with a health care team. And, YOU are the most important person on the health care team.

Together with your health care team, your primary care is planned and coordinated for you. Go to www.mercycareplan.com to:
• Get more information on why the PCMH model might be right for you
• See a list of provider groups participating in PCMH

For more about how to participate in a PCMH, please call Mercy Care Plan Member Services.

Well visits (well exams)
Well visits (well exams) such as, but not limited to, well woman exams, breast exams, and prostate exams are covered for members 21 years of age or older. Most well visits (also called checkup or physical) include a medical history, physical exam, health screenings, health counseling and medically necessary immunizations. (See EPSDT for well exams for members under 21 years of age.)

Tips to keep you healthy

<table>
<thead>
<tr>
<th>ALL MEMBERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Always go to your PCP visits. If you cannot keep your appointment, call to cancel it and make another one.</td>
</tr>
<tr>
<td>• Follow the directions your PCP gives you.</td>
</tr>
<tr>
<td>• If you take prescription medication every day, remember to get refills before you run out. Or, find out about our mail order pharmacy program by calling Mercy Care Plan Member Services.</td>
</tr>
<tr>
<td>• Never share medication with anyone else.</td>
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<tr>
<td>• Eat right, get enough sleep and exercise.</td>
</tr>
<tr>
<td>• Brush your teeth at least two times a day.</td>
</tr>
<tr>
<td>• Always wear your seat belt. It's the law in Arizona.</td>
</tr>
</tbody>
</table>
PLUS, FOR CHILDREN ...

- Make sure your child has his/her shots! Children and teens need shots for good health because shots protect against many diseases. Bring your child's shot record with you to his/her PCP.
- Keep your baby in a car seat. It's the law in Arizona!
- Make sure your child sees the dentist often. Members ages 1 through 20 should see a dentist twice a year.

EPSDT/Children's services (same as well-child visits)

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 U.S.C. 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 U.S.C. 1396d(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the (AHCCCS) state plan.”

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 29 optional and mandatory categories of “medical assistance” as defined in the Medicaid Act. Services covered under EPSDT include all 29 categories of services in the federal law even when they are not listed as covered services in the AHCCCS state plan, AHCCCS statutes, rules, or policies as long as the services are medically necessary and cost effective.

EPSDT includes, but is not limited to, coverage of: inpatient and outpatient hospital services, laboratory and x-ray services, physician services, 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.

The importance of well-child visits

We care about children's health. One of the best ways to keep your child healthy is to take your child each year for a well-child visit. Well-child visits (same as an EPSDT visit or check-up) can help keep children safe from illness and catch problems early. During a well-child visit you have the chance to talk to your child's
doctor and ask questions. For your child's health, it is best that s/he see their doctor each year for a well-child visit, even if your child is healthy.

**Immunizations (shots)**
We care about your child's health. Take your child to see their doctor for regular well-child visits (check-ups) and shots, even if your child is healthy. The best way to protect your child from disease is to make sure that your child gets his/her shots. Children who get shots are protected from getting 16 possibly harmful diseases. Shots can keep your child safe from getting serious illnesses. If you have questions, talk to the doctor about shots at your child's next appointment.

**Dangers of lead exposure and recommended/mandatory testing**
Make sure your child is safe from lead poisoning. Talk to your child's doctor about the risks of lead poisoning during your child's next well-child visit. Lead poisoning is a problem in Arizona. Testing the blood for lead is required for all children ages 1 and 2 that live in a high-risk ZIP code. Your child may be at risk for having lead poisoning if your child lives in a high-risk ZIP code. If your child has lead poisoning in his or her blood, he/she may not appear sick. Lead in your child's blood can cause lifelong illness or even death if not treated. Call your doctor's office and schedule a blood lead test for your child. If you are going to register your child for Head Start, they will require proof that your child has had a blood lead test.

**Childhood obesity and prevention measures**
In children, a high amount of body fat can lead to obesity, weight-related diseases, and increased risk of serious health problems. During a well-child visit, your child's doctor checks Body Mass Index (BMI) to see if your child is at a healthy weight for his or her age, sex and height. If you are concerned about your child's weight, you should talk to the doctor about BMI. The higher a child's BMI, the greater the risk of future health problems. Making healthy choices now can help you and your family reduce these risks.

- Eat five (5) servings a day of fruits and vegetables.
- Spend less than two (2) hours a day in front of a screen (this includes TV, video games, computers, tablets or other mobile devices).
- Be active at least one (1) hour a day.
- Do not drink sweetened beverages.

**The importance of oral health care**
The right oral health care as a child can lead to a lifetime of happy smiles! Good dental habits start in early childhood. Your child's first dentist's appointment should be when the first baby teeth come in. This is usually by age 1. After that, take your child to the dentist every six (6) months. Dental visits may include x-rays, fluoride varnish, fillings, cleanings and sealants. It's never too soon to start good dental health habits. Follow these simple dental care tips:

- Keep your dentist's name and number handy.
- Schedule regular appointments a couple of months ahead of time.
- Make sure you have a ride to your appointment.
- Be on time for your appointment.
- Make sure to bring your member ID card with you to the dentist's office.
- If you must cancel your appointment, call the dentist's office as soon as you can.

Do you need help finding a dentist or help getting a ride? Call Member Services at 602-263-3000 or 1-800-624-3879 (TTY/TDD 711).

**Dental decay prevention measures**
The care and cleaning of your baby's teeth is important for long-term dental health. Even though the first set of teeth (baby teeth) will fall out, tooth decay can make the teeth fall out before they are ready. That makes
the adult teeth come in crooked and out of place. Daily dental care should begin even before your baby's first tooth comes in. Wipe your baby's gums daily with a clean, damp washcloth or gauze. You can also brush the gums gently with a soft, infant-sized toothbrush and water. As soon as the first teeth appear, brush the teeth and gums with water. By the time all your baby's teeth are in, try to brush your child's teeth at least twice a day. It's also important to get kids used to flossing early on. A good time to start flossing is when two (2) teeth start to touch. Talk to your dentist for advice on flossing tiny teeth.

**Dental sealant/fluoride varnish application**
Keeping children's teeth healthy for a lifetime begins with preventive care. Taking your child to the dentist every six (6) months will help keep their teeth healthy. Covered dental services for children include:
- Routine preventive dental services, including oral health screenings, cleanings, fluoride treatments, dental sealant, oral hygiene education, x-rays, fillings and extractions
- Two (2) routine, preventive dental visits per year
- Other therapeutic and medically necessary procedures

**Health guidelines for children**
All children, not just babies, should have well-child checkups and shots (immunizations). Well-child checkups help keep your child healthy and find problems before your child gets sick. Shots protect against many diseases. Make an appointment with your child's PCP at the following ages to keep your child (and teen) healthy.

| Well-child checkups (EPSDT Visits) | • Newborn  
• 3-5 days  
• 1 month  
• 2, 4, 6, 9, 12, 15, 18 and 24 months  
• Annually from ages 3-20 years of age |
| Shots (Immunizations) | • Diphtheria, Tetanus, Pertussis (DTaP)  
• Haemophilus Influenzae type b (Hib)  
• Hepatitis A  
• Hepatitis B  
• Human Papillomavirus (HPV)  
• Influenza (Flu)  
• Measles, Mumps, Rubella (MMR)  
• Meningococcal  
• Pneumococcal (Pneumonia)  
• Inactivated Polio (IPV)  
• Rotavirus (RV)  
• Tetanus, Diphtheria, Pertussis (Tdap)  
• Varicella (Chickenpox) |

**Women's services**
Female members have direct access to preventive and well care services from a gynecologist within Mercy Care Plan's network without a referral from a primary care provider.

It is very important for women who are sexually active to see their PCP or a Mercy Care Plan obstetrician/gynecologist (OB/GYN) every year. Pap tests and mammograms are important tests that can help save your life. A Pap test checks for cervical cancer and a mammogram checks for breast cancer.
Cervical cytology, including pap smears, should be done annually for sexually active women. After three (3) successive normal exams, the test may be less frequent. Mercy Care Plan members can see their PCP or a Mercy Care Plan OB/GYN for a Pap test. If you want to see an OB/GYN, you don't need to see or ask your PCP first. You can find OB/GYN doctors in your Provider Directory or by using the searchable provider directory on the Mercy Care Plan website at www.mercycareplan.com and select “Find a Provider.”

Routine mammography should be done annually after age 40 and at any age if considered medically necessary. You can call your doctor for a mammogram order. You can then schedule your mammogram with the radiology facility. You can find a list of radiology facilities in your area in your Provider Directory or by using the searchable provider directory on the Mercy Care Plan website at www.mercycareplan.com/findaprovider.

**Well-woman preventive care**

An annual well-woman preventive care visit is intended for the identification of risk factors for disease, identification of existing medical/mental health problems, and promotion of healthy lifestyle habits essential to reducing or preventing risk factors for various disease processes. Female members have direct access to preventive and well care services from a gynecologist within the Mercy Care Plan's network without a referral from a primary care provider.

**Benefits of preventive health care**

Getting regular check-ups and screenings is an important part of a woman's health care. These screenings can find problems before you have any signs. Early diagnosis and treatment will generally result in a better outcome. Focusing on preventing disease and illness before they occur will help improve your health and quality of life.

**Description of well-woman preventive care services**

The well-woman preventive care visit includes:

A. A physical exam (well exam) that assesses overall health
B. Clinical breast exam
C. Pelvic exam (as necessary, and according to current recommendations and best standards of practice)
D. Immunizations, screenings and tests as appropriate for your age and risk factors
E. Screening and counseling for help maintaining a healthy lifestyle and minimizing health risks. This includes screening for and counseling about:
   a. Proper nutrition
   b. Physical activity
   c. Elevated Body Mass Index (BMI)
   d. Tobacco use and/or dependency
   e. Substance abuse and/or dependency
   f. Depression
   g. Interpersonal and domestic violence
   h. Sexually transmitted infections
   i. Human Immunodeficiency Virus (HIV)
   j. Family planning
   k. Preconception counseling
      i. Reproductive history
      ii. Sexual practices
      iii. Healthy weight, diet and nutrition
   iv. Physical activity
   v. Oral health care
vi. Chronic disease management
vii. Emotional wellness
viii. Tobacco and substance use, including prescription medications
ix. Recommended time between pregnancies

F. Referrals when further evaluations or treatment is needed

Information on how to obtain well-woman preventive care services
Call your PCP or gynecologist today and schedule an appointment for a well-woman preventive care visit. This visit is provided at no cost.

Assistance with scheduling of appointments
You may seek well-woman care services without your PCP’s approval. If you need help making a well-woman appointment with your doctor, please call Mercy Care Plan Member Services at 602-263-3000 or 1-800-624-3879 (TTY/TDD 711).

Maternity services
Pregnant women need special care. If you are pregnant, please call us to choose an OB/GYN or certified nurse midwife as soon as possible. We will also send you a pregnancy booklet with a lot of information.

You may go directly to a Mercy Care Plan OB/GYN for care. You do not need to see or ask your PCP first. Your PCP will manage your routine non-OB/GYN care. The OB/GYN will manage your pregnancy care. If you prefer, you can choose to have an OB/GYN as your PCP during your pregnancy. If you are not sure you are pregnant, make an appointment with your PCP for a pregnancy test. If you need help scheduling an appointment, call Mercy Care Plan Member Services.

It is important to have early and regular prenatal care during your pregnancy. It will benefit you and your baby. Be sure to keep all of your scheduled prenatal and postpartum visits. We can get you a ride to your doctor’s appointment. Transportation for non-urgent appointments must be set up at least three (3) days in advance. Call Mercy Care Plan Member Services.

Pregnancy and HIV/AIDS testing
If you are pregnant, you will have a complete checkup at your first doctor’s visit. The doctor or nurse will check for infections and sexually transmitted diseases. Voluntary, confidential HIV/AIDS testing services are available at no cost to you. If you test positive for any sexually transmitted disease or HIV, your doctor can help you obtain counseling services and any needed treatment. Treatment is covered.

Pregnancy appointment timeframes
It is important to keep seeing your health care provider during your pregnancy, even if you feel fine. Regular prenatal care can help you have a healthy pregnancy and a healthy baby. It will allow your provider to identify any health conditions and prevent problems before they occur. You should be able to get an appointment inside of the following timeframes:

• First trimester—months 1-3: you should be seen within 14 days of calling the doctor.
• Second trimester—months 4-6: you should be seen within seven (7) days of calling the doctor.
• Third trimester—months 7-9: you should be seen within three (3) days of calling the doctor.

If you think you may have a problem with your pregnancy, your doctor should see you within three (3) days of your call or right away if it is an emergency. Call your doctor immediately if you have any of these symptoms. Don’t wait for them to go away.

• Discharge, blood or water leaking from the vagina
• Low, dull backache
• Feel like you’re going to start your period (period-like cramping)
• Pelvic pressure (like the baby is pushing down)
• Stomach cramps (you may or may not have diarrhea with this)
• Regular contractions that last for over an hour

First visit
• At your first visit, you will have a complete checkup. This checkup includes talking about your health history and the doctor giving you a physical exam. The doctor or nurse will perform routine urine and blood tests. They will also check for infections and sexually transmitted diseases.
• If you are taking any medicine, tell your doctor or nurse midwife at your first visit.

Stay healthy tips for pregnant women
• During your pregnancy, your OB/GYN or nurse midwife will tell you when you need to come back. If something comes up and you need to cancel, be sure to call your provider to let them know and make a new appointment as soon as possible. It is important to keep your appointments so that you and your baby stay healthy.
• You should take folic acid (found in prenatal vitamins) before and during pregnancy to help prevent birth defects of the brain and spinal cord. Take the prenatal vitamins prescribed or recommended by your health care provider, but do not take any additional vitamins on your own. Do not stop taking any medicines without talking to your doctor.
• Smoking, drinking alcohol and using street drugs can cause many problems during pregnancy for a woman and her baby, such as premature birth, birth defects, and infant death. Neonatal abstinence syndrome (NAS) happens when a woman uses certain drugs during her pregnancy. Her baby can go through drug withdrawal after birth. NAS can also occur when a woman takes opioids during pregnancy. Opioids help take away pain and are often prescribed by your doctor after an injury or surgery. Tell your OB provider if you are taking medication for pain even if it is prescribed by another doctor. Babies born with NAS are more likely to have a low birth weight, breathing and feeding problems and seizures. If you are pregnant and drink alcohol, smoke, use street drugs or take opioids, be sure to talk to your doctor or seek help from a local treatment center before quitting. If you do not feel comfortable talking to your doctor or nurse midwife about your problem, call Mercy Care Plan Member Services for help.
• Childbirth classes can help with your pregnancy and delivery. These classes are available at no cost to members. Ask your doctor or nurse midwife about the classes or call to sign up for them at the hospital where your baby will be born.

Labor
If you are in labor and need a ride to the hospital, call 911.

Postpartum
After you deliver your baby, it is important to see your OB/GYN for a postpartum visit. You should schedule these visits within 3-8 weeks (60 days) after having your baby. Sometimes your provider may want to see you more than once during this time to make sure you are healing appropriately, to discuss emotions and feelings and to answer any of your questions.

At this visit, you can also discuss family planning options with your provider. You can then decide what method best fits your needs until you are ready to get pregnant again. Therefore, it is important to keep all of your appointments. If you need help scheduling your postpartum appointment, call Mercy Care Plan Member Services.
Postpartum Depression (PPD)
If you have feelings of sadness that last a long time, are severe and cause you to have problems doing normal daily activities, call your doctor right away. Your doctor will figure out if your symptoms are caused by postpartum depression (PPD) or something else. PPD is more than the “blues.” It’s an illness and needs treatment to get better. If you need to talk to someone because you have troubling thoughts, contact your doctor or nurse right away. **Do not wait to get help.** You can also get behavioral health services from ALTCS behavioral health providers. You don’t need a referral from your doctor. If you need help getting behavioral health services, please contact Mercy Care Plan Behavioral Health Coordinators at 602-263-3000 or 1-800-624-3879 (TTY/TDD 711). For all emergencies please dial 911.

Low birth weight/very low birth weight
Mothers who do not get prenatal care are three (3) times more likely to have babies with low birth weight. A baby with low birth weight may have other problems. Their tiny bodies are not as strong and they may have a harder time eating, gaining weight and fighting infection. A baby whose mother does not get prenatal care is five (5) times more likely to die. Regular prenatal visits with a doctor can help keep you and your baby healthy. Regular prenatal visits can help prevent pre-term births and low birth weight babies.

Risks associated with elective labor inductions/C-sections
At least 39 weeks of pregnancy gives a baby the time he/she needs to grow before being born. Major organs, like the brain, lungs and liver, are still growing. Eyes and ears are developing. She/he is learning to suck and swallow. It is important to carry your baby to term to make sure your baby develops fully. Scheduling a C-section or inducing labor prior to 39 weeks without a medical reason to do so, can be dangerous for you and your baby. But Sometimes though, an induction is medically necessary for you and your baby’s health. Your doctor will talk to you if you need to deliver early for a medical reason.

If the induction does not work, a C-section may be needed. For baby, some risks are breathing problems including respiratory distress, difficulty eating, learning and behavior problems, and jaundice, which can lead to brain damage. For you, some risks are infection and tears in the uterus causing severe bleeding. Once you have a C-section, you may be more likely to need a one in future pregnancies. The more C-sections you have, the more problems you and your baby may have.

Healthy Pregnancy Tips

**Nutrition and healthy eating:** Your doctor will tell you how much weight to gain during your pregnancy. Most women gain about 25 to 35 pounds. Gaining too much or too little weight can be bad for you or your baby. The key to achieving and staying at a healthy weight is not about short term changes. It is about a lifestyle that includes healthy eating and regular physical activity. If you are underweight or overweight, talk with your doctor about ways to reach and stay at a healthy weight before you get pregnant. Drink at least 10 cups of liquids every day. Eight (8) of these cups of liquids should be water. Eat healthy snacks and meals. Instead of eating three (3) big meals a day, try eating five (5) or six (6) small meals and snacks. Stay away from foods with no or low nutritional value. Stay away from foods that could make you or your baby sick, such as raw fish and shellfish, raw or undercooked eggs, soft cheeses, cheeses not made in the United States, unpasteurized milk and unpasteurized juices.

**Physical activity:** You do not have to stop all physical activity because you are pregnant, but you may have to change the type of physical activity that you do. Talk to your doctor about the level of physical activity that is safe for you.

**Getting plenty of sleep:** You may feel very tired and need more sleep than you are used to, especially in the first three (3) months of your pregnancy.
Sexually transmitted diseases: We encourage every pregnant woman to be tested for sexually transmitted diseases (STDs) and HIV (the virus that causes AIDS). Check with your doctor about how to get these tests. These tests are at no cost to you. If you test positive for any STD or HIV, your doctor can help you get counseling services and any needed treatment. Treatment is covered.

Prescribed medicines: Prescribed medicines that you take every day are important for your physical and emotional health. When you are pregnant, your body will need extra help, such as certain vitamins and folic acid (a B vitamin). Take the prenatal vitamins prescribed or recommended by your health care provider, but do not take any additional vitamins on your own. Do not stop taking any medicines without talking to your doctor.

Risky behaviors: Quitting smoking, drinking and using drugs can be hard, but these are the best things that you can do to protect your baby. Smoking, drinking alcohol and using drugs can cause many problems during pregnancy for a woman and her baby, such as premature birth, birth defects and infant death. If you are pregnant and cannot stop drinking, smoking, or using drugs - get help. Be sure to talk to your doctor or seek help from a local treatment center. If you do not feel comfortable talking to your doctor or nurse midwife about your problem, call Mercy Care Plan Member Services for help.

Dangers of lead exposure to mother and baby
Lead is a toxic metal that can be used to make a variety of products and materials. Lead exposure during pregnancy can cause miscarriage, pre-term birth, low birth weight and developmental delays. Lead poisoning is a condition caused by swallowing or breathing in lead. Lead poisoning can affect children, adults, and pregnant women who can pass it on to their unborn babies. Young children are at greatest risk since their bodies take in lead easily. Children and adults who have lead poisoning might look and feel healthy and show no signs of illness, but they still need to be treated. Many cases of lead poisoning go undiagnosed and untreated. The only way to detect lead poisoning is by asking your doctor to perform a simple blood test.

Sudden Infant Death Syndrome (SIDS)
Always place your baby on his/her back to sleep. SIDS is the sudden and unexplained death of an infant. Babies put on their backs to sleep have less chance of dying from SIDS. Put your baby to sleep on a firm surface. Do not use fluffy blankets, pillows, stuffed animals, waterbeds, sheepskins or other soft bedding in your baby's crib.

Women, Infants and Children (WIC) is a community resource for women who are pregnant, breastfeeding or postpartum, and for infants and children under 5 years of age. It is a program that provides food, breastfeeding education and information about healthy eating. Peer counseling is a core service available to all women in WIC. Women who take part in the WIC program have children with improved birth weight and fewer pre-term deliveries. Women who take part in the WIC program during pregnancy may have fewer deliveries of infants who are small for their gestational age. For more information, refer to the “Community Resources” section at the back of this handbook or call Mercy Care Plan Member Services.

Family planning services
Family planning services are administered by Aetna Medicaid Administrators, LLC. Talk to your PCP if you need help with family planning services. These services are covered at no cost and are available to male and female members of reproductive ages. You do not have to get a referral before choosing a family planning provider. Keeping your family planning appointments will help your provider identify any health conditions and prevent problems before they occur.
Talk to your PCP if you need help with family planning. Covered services include:
• Contraceptive counseling
• Birth control pills
• Emergency oral contraceptives
• Injectable contraceptives
• Subdermal contraceptive implants
• Vaginal rings
• IUD (Intrauterine devices)
• Diaphragms
• Condoms
• Spermicidal foams, jellies and creams
• Male and female sterilization (members must be 21 or older to have tubal ligations and vasectomies)
• Post-coital emergency oral contraception - no prior authorization is required
• Medical and lab exams and radiological procedures, including ultrasounds related to family planning
• Treatment of complications resulting from contraceptive use, including emergency treatment
• Hysteroscopic tubal sterilization
• Testing and treatment for sexually transmitted infections
• Natural family planning

The following are NOT covered family planning services:
• Infertility services, including diagnostic testing, treatment or reversal of surgical infertility
• Pregnancy termination counseling
• Pregnancy terminations and hysterectomies

You may seek family planning services without your PCP’s approval by doing the following:
1. Make an appointment with the provider. The provider can be any provider of medical services, such as a primary care physician, nurse practitioner, etc. The provider can be in the Mercy Care Plan network, or they don’t have to be. You do not need a referral for family planning services.
2. When you make the appointment, tell the office you want to talk about getting family planning services and/or supplies.
3. Keep the appointment. Show the provider your Mercy Care Plan member ID card.
4. At the appointment, talk about your options for family planning services or supplies.
5. You will not be billed for the visit and you do not have to pay a co-pay. If you are asked to pay a co-pay or billed for the visit, please call Member Services at 602-263-3000 or 1-800-624-3879 (TTY/TDD 711) right away.
6. Your provider will tell you how to get the supplies you need. Follow their instructions to get them and to use them.

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

Dental services

Dental services for members 21 years of age or older
Members 21 years of age or older may receive medically necessary dental benefits up to $1,000 per contract year (October 1 - September 30). This coverage includes dentures.

Dental homes for members under 21 years of age
Mercy Care Plan assigns all members under 21 years of age to a dental home. A dental home is where you and a dentist work together to best meet dental health needs. Having a dental home builds trust between you and the dentist. It is a place where you/your child can get regular, ongoing care, not just a place to go when you/your child have a dental problem. A “dental home” may be an office or facility where all dental services are provided in one place. You can choose or change your assigned dental provider. Member Services can help you with the following:
   • Find the name, address and telephone number of your dental home or your child's dental home
   • Change your dental home provider or help you find a different dental home provider
   • Help you make dental appointments for you or your child
   • Arrange transportation to or from the appointment

Dental services for members under 21 years of age
Two (2) routine preventive dental visits are covered per year. Visits to the dentist must take place within six months and one day after the previous visit. Your child should have his or her first dental visit by one year of age. Members under 21 years of age do not need a referral for dental care.

If you need to change or cancel your dental appointment or your child's dental appointment, please call your dental provider 24-48 hours in advance.

If you need help, please call Mercy Care Plan Member Services at 602-263-3000 or 1-800-624-3879 (TTY/TDD 711).

Condition management services

Mercy Care Plan has special programs available to members with the following conditions:
• Asthma
• Congestive Health Failure (CHF)
• Chronic Obstructive Pulmonary Disease (COPD)
• Diabetes

The condition management program is an optional part of your regular benefits and provided at no cost to you. If you enroll in one of these programs, you may receive mailed information about your condition, or one of our nurses will work with you and your doctor to give you more information on what your condition means to your everyday life. You will also receive the names and contact numbers for resources in your community.
that can help you manage your illness. The nurse will work with you to put together a care plan to help you meet your goal of feeling better. They can even help you with quitting tobacco.

If you would like more information about these programs, call Member Services at 602-263-3000 or 1-800-624-3879 (TTY/TDD 711) between 7 a.m. and 6 p.m., Monday through Friday. To leave a message for the Care Management team, call 602-453-8391 and someone will return your call the next business day.

**Pharmacy services**

If you need medicine, your doctor will choose one from Mercy Care Plan's list of covered medications directory (called a formulary) and write you a prescription. Mercy Care Plan's directory of covered medicines is reviewed and updated regularly by doctors to make sure you receive safe, effective medicines. Some over the counter medicines are covered when your provider orders them. If you want a copy of the list, call Member Services or go to our website at [www.mercycareplan.com](http://www.mercycareplan.com) for the most up to date list.

If your medicine is not on the list of covered medications and you cannot take any other medicines except the one prescribed, your doctor may ask Mercy Care Plan to make an exception. If you have Medicare, you will need to pay the designated copay for each of your prescriptions.

If you have other insurance (not Medicare), Mercy Care Plan will pay the copayments only if the medication is also on the Mercy Care Plan medication list. The pharmacy should process the prescriptions through Mercy Care Plan. Do not pay any copayments yourself. Mercy Care Plan may not be able to pay you back. Please see the section on Medicare copayments for more information. If you have any questions or trouble filling a prescription at the pharmacy, or are turned away, please contact Mercy Care Plan. Mercy Care Plan Member Services can help you with your prescriptions. If you have questions or problems outside the Mercy Care Plan business hours, please call the Mercy Care Plan nurse line. Call Mercy Care Plan and select the “speak to a nurse” option.

**Pharmacies**

All prescriptions must be filled at a pharmacy in Mercy Care Plan's network. You can find a list of pharmacies in the Mercy Care Plan Provider Directory. Visit our website at [www.mercycareplan.com](http://www.mercycareplan.com) and select “Find a Pharmacy.”

If you need pharmacy services after hours, on weekends or holidays, many pharmacies are open 24 hours, 7 days a week. Look in your Provider Directory or online to find a pharmacy with extended hours or 24 hour, 7 days a week pharmacies. You can find a list of pharmacies in the Mercy Care Plan Provider Directory, or our website at [www.mercycareplan.com](http://www.mercycareplan.com). Select “Find a Pharmacy” in the upper right corner of the screen. If you have any questions or trouble filling a prescription while you are at the pharmacy, please contact Mercy Care Plan. Mercy Care Plan Member Services can help you with your prescriptions Monday through Friday from 7 a.m. to 6 p.m. If you have questions or problems outside the Mercy Care Plan business hours, please call the Mercy Care Plan nurse line. Call Mercy Care Plan Member Services and select the “speak to a nurse” option.

**What you need to know about your prescription**

Your doctor or dentist may give you a prescription for medication. If you live in a nursing home or assisted living facility, the staff will take care of managing your medications for you and getting refills.

Be sure to let the staff know about any medications you get from another doctor or non prescription or herbal medications that you buy. 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 of the medication and what should you do if a side effect happens?
• What will happen if I do not take this medication?

Carefully read the medication information from the pharmacy. It has information on things you should and should not do and possible side effects of the medication. If you have questions, please ask your pharmacist.

**e-Prescribing**
Many doctors can now electronically send prescriptions directly to pharmacies. This can help save you time and an extra trip. Ask your doctor if e-Prescribing is an option for you.

**Refills**
If you live in a nursing home or assisted living facility, the staff will take care of managing your medications for you and getting your refills. The label on your medication bottle tells you the number of refills you can get. You may only get one refill at a time for each prescription.

If your doctor has not ordered your refills, be sure to call him or her at least five (5) days before your medicine runs out. Talk to him or her about getting a refill. Your doctor may want to see you before giving you a refill.

If you have any questions or trouble filling a prescription at the pharmacy, please contact Mercy Care Plan. Mercy Care Plan Member Services can help you with your prescriptions. Mercy Care Plan Member Services is available Monday through Friday from 7 a.m. to 6 p.m. If you have questions or problems outside the Mercy Care Plan business hours, please call the Mercy Care Plan nurse line. Call Mercy Care Plan and select the “speak to a nurse” option.

**Mail order prescriptions**
If you take medicine for an ongoing health condition, you can have your medicines mailed to your home. Mercy Care Plan works with a company to give you this service. You can get your prescriptions mailed to you at no additional cost to you.

If you choose this option, your medicine comes right to your door and you can schedule your refill. Here are some features of mail order prescriptions:
• Pharmacists check each order for safety.
• You can order refills by mail, by phone, online, or you can sign up for automatic refills.
• You can talk with pharmacists by phone at any time 24 hours a day, 7 days a week.

To request a refill order form, call Mercy Care Plan Member Services at **602-263-3000 or 1-800-624-3879** (TTY/TDD **711**).

You can also go to [www.mercycareplan.com](http://www.mercycareplan.com) and select, “Contact Us.” You can register online with CVS Caremark at [www.caremark.com/wps/portal/REGISTER-ONLINE](http://www.caremark.com/wps/portal/REGISTER-ONLINE). Once registered, you will be able to order refills, renew your prescription and check the status of your order.

**Diabetes testing supplies**
If you have diabetes, Mercy Care covers certain blood glucose meters and test strips. Please see Mercy Care Plan’s medication list (formulary) for a list of covered meters and test strips. If you need a meter and test strips, ask your doctor to write a prescription for you. You can pick up your meter and test strips at a pharmacy listed in your Mercy Care Plan provider directory.
Exclusive prescriber program

Mercy Care Plan has an exclusive prescriber program. This program is to better support members who are taking medications that could be dangerous in large amounts, without good communication with the prescribers. You may be enrolled in this program if the following have been true for you in a three (3) month time period:

- You have had four (4) or more prescribers; and
- You have been prescribed four (4) or more different drugs that can be habit forming; and
- You have filled drug prescriptions at four (4) or more pharmacies.

You may also be enrolled in this program if:

- You have received 12 or more prescriptions of habit forming drugs in the past three (3) months.
- You have presented a forged or altered prescription to your pharmacy.

Mercy Care Plan will notify you in writing 30 days before you are enrolled in the exclusive prescriber program. When you are enrolled in the exclusive prescriber program Mercy Care Plan will assign you to just one (1) doctor. This doctor will be responsible for the prescribing and oversight of habit forming drugs. Mercy Care Plan will only pay for habit forming drug prescriptions written by this one (1) doctor. This applies to medications written at discharge from the emergency room.

We will also work with you and the doctors who order your drugs to make sure you are only taking the drugs you need. This will be in effect for up to a 12 month period. We will review your records after 12 months and let you know if the assignment to the doctor will be continued. If you do not agree with this decision, you may submit a written request for a State Fair Hearing. If you are currently receiving treatment for an active oncology diagnosis, are in hospice care, reside in a skilled nursing facility for custodial care, or if you have Medicare you shall not be subject to the exclusive prescriber program requirements.

Durable Medical Equipment (DME)

Members can get medically necessary Durable Medical Equipment (DME). Medically necessary DME may be provided to Mercy Care Plan members living in, or being discharged to, home and community based settings. DME is ordered by the primary care provider. Case managers may assist in coordinating this process.

Skilled Nursing Facilities (SNF) are required to provide non-customized DME to members while residing in SNFs.

Medically necessary customized equipment and specialty beds may be provided to members by Mercy Care Plan. Customized DME is medical equipment that is made special for one (1) member and cannot be used by other members.

Behavioral health services

Behavioral health services may help you with personal problems that may affect you and your family. Some problems may be from depression, anxiety, or using drugs or alcohol. Some services may be provided in your home, nursing home or assisted living facility. Mercy Care Plan has a behavioral health coordinator who helps case managers arrange needed behavioral health services for our members.

Covered behavioral health services include:

- Behavior management (personal care, family support, home care training, peer support)
- Behavioral health case management services (with limitations)
- Behavioral health nursing services
• Emergency behavioral health care
• Emergency and non-emergency transportation
• Evaluation and assessment
• Individual, group and family therapy and counseling
• Inpatient hospital services
• Non-hospital inpatient psychiatric facilities
• Opioid agonist treatment
• Lab and radiology services for psychotropic medication regulation and diagnosis
• Partial care (supervised day program, therapeutic day program and medical day program)
• Psychosocial rehabilitation (living skills training, health promotion, supportive employment)
• Psychotropic medication
• Psychotropic medication adjustment and monitoring
• Respite care (with limitations)
• Substance abuse transitional facility
• Screening
• Home care training to home care client

How to get behavioral health services
You do not need a referral from your doctor for behavioral health services. Call your case manager to discuss your behavioral health service need and he/she will assist you in obtaining services. If you need a ride to an appointment, call Member Services.

Behavioral health emergencies
If you think you might hurt yourself or someone else, call 911. You can also call our crisis line if you feel overwhelmed and it is hard to cope with stressful things in your life.

Mercy Care Plan Behavioral Health Crisis Line: 1-800-876-5835
Trained crisis intervention specialists are available around the clock, every day of the year to provide triage and support services.

There are many ways that they can help, including:
• Talking and helping you calm down
• Talking about your worries about a loved one
• Helping you deal with difficult relationships
• Talking about thoughts of suicide
• Stabilizing violent or threatening situations
• Presenting options for dealing with other urgent situations

State and national crisis lines:
• Central Arizona: 602-222-9444, TTY: 602-274-3360
• Southern Arizona:
  – Cochise, Graham, Greenlee, La Paz, Pima, Pinal, Santa Cruz and Yuma Counties: 1-866-495-6735
  – Pima County: 520-622-6000
• Veterans Crisis Line: 1-800-273-8255, press 1
National crisis text line: Text HOME to 741741, about any type of crisis.  
http://www.crisistextline.org/how-it-works

National suicide prevention hotline: 1-800-273-8255

Warm Lines: Warm Line specialists offer peer support for callers who just need to talk. The Warm Line is a no-cost and confidential telephone service staffed by peers who have, themselves, dealt with behavioral health issues. Warm Line staff can relate to behavioral health situations because many have been through the same experiences themselves. Warm Line specialists offer peer support for callers who just need someone to talk to.  
• Central Arizona: 602-347-1100. Available 24 hours a day, seven days a week.  
• Southern Arizona: 520-770-9909 (Pima County) or 1-877-770-9912 (all other southern Arizona counties). Available seven days a week from 8 a.m. to midnight.

Behavioral health advocacy resources  
Arizona has a number of advocacy groups and resources available to assist you with a variety of your behavioral health needs. These include:  
• Arizona Center for Disability Law, Phoenix location: 602-274-6287 or 1-800-927-2260  
• Arizona Center for Disability Law, Tucson location: 520-327-9547 or 1-800-922-1447  
• National Alliance on Mental Illness (NAMI): 602-244-8166  
• National Alliance on Mental Illness of Southern Arizona: 520-622-5582  
• Mental Health America of Arizona: 602-214-9507  
• National Domestic Violence Hotline: 1-800-799-7233  
• Arizona Coalition to End Sexual & Domestic Violence: 602-279-2900 or 1-800-782-6400  
• Childhelp National Child Abuse Hotline: 1-800-422-4453

Arizona’s vision for the delivery of behavioral health services  
All behavioral health services are delivered according to the following system principles. AHCCCS supports a behavioral health delivery system that includes:  
• Easy access to care,  
• Behavioral health recipient and family member involvement,  
• Collaboration with the Greater Community,  
• Effective Innovation,  
• Expectation for Improvement, and  
• Cultural Competency.

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

4. Accessible services:
   a. Children have access to a comprehensive array of behavioral health services, sufficient to ensure that
they receive the treatment they need,
   b. Case management is provided as needed,
   c. Behavioral health service plans identify transportation the parents and child need to access
behavioral health services, and how transportation assistance will be provided, and
   d. Behavioral health services are adapted or created when they are needed but not available.

5. Best practices:
   a. Behavioral health services are provided by competent individuals who are trained and supervised,
   b. Behavioral health services are delivered in accordance with guidelines adopted by ADHS that
incorporate evidence-based “best practices.”
   c. Behavioral health service plans identify and appropriately address behavioral symptoms that are
reactions to death of a family member, abuse or neglect, learning disorders, and other similar
traumatic or frightening circumstances, substance abuse problems, the specialized behavioral
health needs of children who are developmentally disabled, maladaptive sexual behavior, including
abusive conduct and risky behavior, and the need for stability and the need to promote permanency
in class members’ lives, especially class members in foster care, and
   d. Behavioral health services are continuously evaluated and modified if ineffective in achieving
desired outcomes.

6. Most appropriate setting:
   a. Children are provided behavioral health services in their home and community to the extent
possible, and
   b. Behavioral health services are provided in the most integrated setting appropriate to the child's
needs. When provided in a residential setting, the setting is the most integrated and most home-like
setting that is appropriate to the child's needs.

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

8. Services tailored to the child and family:
   a. The unique strengths and needs of children and their families dictate the type, mix, and intensity of
behavioral health services provided, and
   b. Parents and children are encouraged and assisted to articulate their own strengths and needs, the
goals they are seeking, and what services they think are required to meet these goals.

9. Stability:
   a. Behavioral health service plans strive to minimize multiple placements,
   b. Service plans identify whether a class member is at risk of experiencing a placement disruption and,
if so, identify the steps to be taken to minimize or eliminate the risk,
   c. Behavioral health service plans anticipate crises that might develop and include specific strategies
and services that will be employed if a crisis develops,
d. In responding to crises, the behavioral health system uses all appropriate behavioral health services to help the child remain at home, minimize placement disruptions, and avoid the inappropriate use of the police and the criminal justice system, and  
e. Behavioral health service plans anticipate and appropriately plan for transitions in children's lives, including transitions to new schools and new placements, and transitions to adult services.

10. Respect for the child and family's unique cultural heritage:  
   a. Behavioral health services are provided in a manner that respects the cultural tradition and heritage of the child and family, and  
   b. Services are provided in Spanish to children and parents whose primary language is Spanish.

11. Independence:  
   a. Behavioral health services include support and training for parents in meeting their child's behavioral health needs, and support and training for children in self-management, and  
   b. Behavioral health service plans identify parents' and children's need for training and support to participate as partners in the assessment process, and in the planning, delivery, and evaluation of services, and provide that such training and support, including transportation assistance, advance discussions, and help with understanding written materials, will be made available.

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

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

1. Respect - Respect is the cornerstone. Meet the person where they are without judgment, with great patience and compassion.

2. Persons in recovery choose services and are included in program decisions and program development efforts - A person in recovery has choice and a voice. Their self-determination in driving services, program decisions and program development is made possible, in part, by the ongoing dynamics of education, discussion, and evaluation, thus creating the “informed consumer” and the broadest possible palette from which choice is made. Persons in recovery should be involved at every level of the system, from administration to service delivery.

3. Focus on individual as a whole person, while including and/or developing natural supports - A person in recovery is held as nothing less than a whole being: capable, competent, and respected for their opinions and choices. As such, focus is given to empowering the greatest possible autonomy and the most natural and well-rounded lifestyle. This includes access to and involvement in the natural supports and social systems customary to an individual's social community.

4. Empower individuals taking steps towards independence and allowing risk taking without fear of failure - A person in recovery finds independence through exploration, experimentation, evaluation, contemplation and action. An atmosphere is maintained whereby steps toward independence are encouraged and reinforced in a setting where both security and risk are valued as ingredients promoting growth.

5. Integration, collaboration, and participation with the community of one’s choice - A person in recovery is a valued, contributing member of society and, as such, is deserving of and beneficial to the community. Such integration and participation underscores one's role as a vital part of the community, the community dynamic being inextricable from the human experience. Community service and volunteerism is valued.
6. Partnership between individuals, staff, and family members/natural supports for shared decision making with a foundation of trust - A person in recovery, as with any member of a society, finds strength and support through partnerships. Compassion-based alliances with a focus on recovery optimization bolster self-confidence, expand understanding in all participants, and lead to the creation of optimum protocols and outcomes.

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

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

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

**Multi-specialty interdisciplinary clinics specialties**

Mercy Care Plan has contracted with several multi-interdisciplinary specialty clinics to meet the unique health care requirements of special needs children by offering primary and specialty care in a single location. The clinics provide a full range of pediatric specialty care. The range of available specialties include: Family Practice, Physical and Occupational Therapy, Speech, Audiology, Plastic Surgery, Orthopedics and Neurology. You can make, change or cancel appointments directly with the Multi-Specialty Interdisciplinary Clinic by calling them. The telephone numbers for the clinics are listed below.

**Metro Phoenix Region**

**DMG Children's Rehabilitative Services**

3141 N. 3rd Ave.
Phoenix, AZ 85013
602-914-1520
1-855-598-1871

**Southern Region**

**Children's Clinics for Rehabilitative Services**

2600 N. Wyatt Dr.
Tucson, AZ 85712
520-324-5437
1-800-231-8261

**Authorizations**

In some cases, your doctor may decide that your condition requires special services. Mercy Care Plan wants to know about these situations in advance so that we can make sure that we get you the care you need. These services may require prior authorization.
Your doctor will submit a request to Mercy Care Plan explaining your condition and actions that he/she would like to take. You will receive a written notification (Notice of Adverse Benefit Determination) within 14 calendar days telling you if the request is denied and what to do next (if urgent, you will receive the notification no later than 72 hours following the receipt of the authorization request unless an extension is in effect. 42 CFR 438.210(d.) & AAC R9-34-206(A.)

If the Notice of Adverse Benefit Determination letter does not fully address your concerns, you can contact AHCCCS Medical Management at 602-417-4000 or 1-800-654-8713 (if outside of Maricopa County).

**How Mercy Care Plan determines urgency of requests:**

**Routine** - A routine request for a service will be reviewed within 14 days. We will send a written notification (Notice of Adverse Benefit Determination) to you within 14 calendar days if the request is denied. The notice will tell you what to do next.

**Urgent** - your physician believes that your condition is not life-threatening, but it should be handled quickly to make sure it does not worsen. If the medical records or the requested services look urgent to the Mercy Care Plan medical reviewer, we will expedite the standard process. You will receive a written notification (Notice of Adverse Benefit Determination) no later than 72 hours following the receipt of the authorization request if the request is denied. This letter will explain what to do next.

Sometimes, we will need more information in order to make our decision. If this is the case, we may need to ask your doctor for an extension of up to 14 calendar days. If we ask for an extension, we will let you and your doctor know what information we need to help us decide. If we do not receive the additional information within the 14 day period, we may deny the request for prior authorization.

If we ask for an extension or change the urgency level of your request, you may file what is called a Grievance (see Grievances in this handbook). Please send your grievances to:

Mercy Care Plan  
4350 E Cotton Center Blvd.  
Building D  
Phoenix, AZ 85040

**How do we make our decision about your request?**

We provide a list of services that require prior authorization on our website (www.mercycareplan.com). If you would like more information about how these decisions are made, contact Member Services. They can get you the list of criteria Mercy Care Plan uses to make these decisions. You have the right to review this list to see how we make our decisions. Our prior authorization decisions are based on Practice Guidelines and Clinical Criteria that are found on the internet (www.guideline.gov).

If Mercy Care Plan does not fully approve the service, one of the following actions may be taken:

- The denial or limited authorization of a service you or your doctor has requested.
- The denial of payment for a service, either all or part.
- Failure to provide services in a timely manner.
- Failure to act within certain timeframes for grievances and appeals.
- Denial of a rural member’s request to get services out of the network when Mercy Care Plan is the only health plan in the area.
- The reduction, suspension or ending of an existing service.

When an action takes place, Mercy Care Plan is required to issue a Notice of Adverse Benefit Determination. (For more information, please see the Notice of Adverse Benefit Determination section later in this handbook).

Mercy Care Plan does not have any restrictions on freedom of choice among providers.
Important information

Cost sharing

As an ALTCS member, you may have to contribute toward the cost of your care. What costs might you have to pay?

Share of cost

ALTCS will decide what your share of cost will be based on your income and certain expenses. They will send you a notice telling you the amount. If you live in a nursing home, the nursing home will collect your share of cost from you every month. If you live in an alternative residential setting or assisted living facility you will have to pay “room and board” to the facility, but you may also have a share of cost that ALTCS has set. If you live at home, you probably will not have a share of cost since you already pay for living expenses. If you live at home or an assisted living facility, and do have a share of cost, Mercy Care Plan will collect the money from you or your representative.

People who are enrolled in ALTCS are not subject to copays for ALTCS services.

Getting bills for services

When can you be billed for services?

If you get services that are not covered or not approved by Mercy Care Plan, you may be billed.

• Talk to your doctor about payment options before getting any non-covered health care service.

• If you ask for a service that is not a covered benefit and sign a statement agreeing to pay the bill, you are responsible to pay for it.

• If you pay for a service as requested by your provider, we may not be able to pay you back.

What actions should you take if you are billed for services?

If you get a bill for a covered service:

• Call the provider right away.

• Give them all of your insurance information and Mercy Care Plan’s address.

Mercy Care Plan
350 E Cotton Center Blvd,
Building D
Phoenix, AZ 85040

• Do not pay the bill yourself.

• If you still get bills, after giving the provider your health care information, please call Member Services for help.

• Sometimes, you may be eligible for covered benefits back to the date you applied for AHCCCS. If you already paid for services during this time, you should first ask the provider to bill Mercy Care Plan. Then ask the provider to pay you back. If they refuse to pay you back and bill Mercy Care Plan, then:

• Send your paid receipts to Member Services.
  – Include a detailed note explaining why you paid for services.
  – Receipts must be received by Mercy Care Plan within six months from the date you received the service.

• You should not pay for covered services or medicines after you have joined Mercy Care Plan. We cannot pay you back.
Other health insurance

If you have other insurance, here are some important things to know.

1. Always give pharmacies, doctors and hospitals your other health insurance information as well as your Mercy Care Plan information.

2. Your other health insurance pays for your health care expenses FIRST. After they pay, Mercy Care Plan will pay its part. Call Member Services to provide Mercy Care Plan with the name, address, and phone number of your primary insurance provider.

If you are in an accident and get treatment for your injuries, you must report it to your case manager.

Medicare copayments, coinsurance and deductibles

Qualified Medicare Beneficiary (QMB) copayments and deductibles

If you meet certain income and resource limits, you may be able to get into a program called Qualified Medicare Beneficiary (QMB) in addition to ALTCS. QMB members may get all ALTCS services as well as Medicare Parts A and B services. QMB members may receive Medicare services that are not covered by ALTCS, like chiropractic services. AHCCCS pays the Medicare Part B premium each month for QMB members.

If you have Medicare, QMB or Medicare HMO, they will pay for your services first.

If you are entitled to AHCCCS covered services and Medicare Parts A & B, then:
• Mercy Care Plan is responsible for sharing in the cost for AHCCCS covered services and for certain Medicare services not covered by AHCCCS, like chiropractic.
• Mercy Care Plan will pay your coinsurance, deductible or copayment amounts to your doctor. Do not pay your copayments yourself. Ask your PCP to bill Mercy Care Plan for the copayment.

If you have Medicare:
• You are responsible for your pharmacy copayments for Medicare Part D.

If you are a QMB member:
• Mercy Care Plan may pay for services not covered by AHCCCS or from a provider who is not part of our network.

Unless you have an emergency, if you choose to go to another provider who is not one of the Mercy Care Plan approved doctors found in your Provider Directory, or not with your Medicare HMO:
• You would be responsible for paying your Medicare coinsurance, deductibles or copayments. Please call Member Services if you have questions.

Dual-eligible members: payment for medications

AHCCCS covers medications, which are medically necessary, cost effective, and allowed by federal and state law.
• For AHCCCS recipients with Medicare: AHCCCS does NOT pay for any medications paid by Medicare or for the cost-sharing (coinsurance, deductibles, and copayments) for these medications. AHCCCS and its contractors are prohibited from paying for these medications or the cost-sharing (coinsurance, deductibles, and copayments) for medications available through Medicare Part D even if the member chooses not to enroll in the Part D plan.
• AHCCCS does not pay for barbiturates to treat epilepsy, cancer, or mental health problems or any benzodiazepines for members with Medicare. This is because federal law requires Medicare to begin paying for these medications. Some of the common names for benzodiazepines and barbiturates are:

<table>
<thead>
<tr>
<th>Generic name</th>
<th>Brand name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alprazolam</td>
<td>Xanax</td>
</tr>
<tr>
<td>Diazepam</td>
<td>Valium</td>
</tr>
<tr>
<td>Lorazepam</td>
<td>Ativan</td>
</tr>
<tr>
<td>Clorazepate Dipotassium</td>
<td>Tranxene</td>
</tr>
<tr>
<td>Clordiazepoxide Hydrochloride</td>
<td>Librium</td>
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<tr>
<td>Clonazepam</td>
<td>Klonopin</td>
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<tr>
<td>Oxazepam</td>
<td>Serax</td>
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<tr>
<td>Temazepam</td>
<td>Restoril</td>
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<tr>
<td>Phenobarbital</td>
<td>Phenobarbital</td>
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<tr>
<td>Mebaral</td>
<td>Mephobarbital</td>
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<tr>
<td>Mebaral</td>
<td>Mephobarbital</td>
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Notice of Adverse Benefit Determination

When a service that you are already receiving or have requested is not approved (denial), we will send you and your provider a written notification called a Notice of Adverse Benefit Determination. There are specific time-frames for when you will receive a Notice of Adverse Benefit Determination.

• If you, your representative or your provider makes a new request for a service, you will receive your notification within 14 calendar days (if urgent, you will receive the notification within 72 hours following the receipt of the authorization request).

• If a service that you are already receiving is reduced, suspended, or ended, you will receive a Notice of Adverse Benefit Determination 10 calendar days before the change occurs.

• If you or your representative request an increase in home and community based services authorized by your case manager and your request is denied, the same process is followed.

The Notice of Adverse Benefit Determination letter lets you know:

• What action was taken and the reason.
• Your right to file an appeal and how to do it.
• Your right to ask for a fair hearing with AHCCCS and how to do it.
• Your right to ask for an expedited resolution and how to do it.
• Your right to ask that your benefits be continued during your appeal, how to do it and when you may have to pay the costs for the services. You or your representative have the right to request an extension to give us information to help us make a decision.
• If you receive a Notice of Adverse Benefit Determination letter that does not tell you what you asked for, what we decided, or the reason why, you or your representative can call us.
  – We will look at the letter and, if needed, write a new letter that better explains the services and the action.

If you or your representative still do not understand the Notice of Adverse Benefit Determination letter, you have the right to contact AHCCCS Medical Management at 602-417-4000 or 1-800-654-8713 (if outside of Maricopa County).
You have the right to receive a reply from Mercy Care Plan within 30 calendar days to your request for a copy of the records. The response may be a copy of the record or a written denial. A written denial will include the reason for the denial and information about how to seek review of the denial. You can ask Member Services to tell you about how Mercy Care Plan makes these decisions. You can also ask Member Services to mail you a copy of the list of criteria.

### Appeals

If you disagree with our decision described in the Notice of Adverse Benefit Determination letter, you have the right to request an appeal. An appeal is a formal procedure asking us to review the request again and confirm if our original decision was correct. During this process, you may submit additional supporting documents or information that you believe would support a different outcome and decision.

You, your representative, or a provider acting with your written permission, may request an appeal with us. The appeal must be submitted within 60 calendar days from the date on your Notice of Adverse Benefit Determination letter. The appeal may be submitted in writing or by telephone. If you need an interpreter, one will be provided. We will not retaliate against you or your provider for filing an appeal.

To file an appeal, you must mail, call or fax the request using the following:

Mercy Care Plan  
Appeals Department  
4350 E Cotton Center Blvd.  
Building D  
Phoenix, AZ 85040  
Phone: **602-453-6098 or 1-800-624-3879**  
Fax: **602-230-4503**

**Request for Standard Appeal**

When we get your appeal, we will send you a letter within five (5) calendar days. This letter will let you know that we got your appeal and how you can give us more information. If you are appealing services that you want to continue while your case is reviewed, you must file your appeal no later than 10 calendar days from the date on the Notice of Adverse Benefit Determination letter.

In most cases, we will resolve your appeal within 30 calendar days. Sometimes, we might need more information to make a decision. When this occurs and we believe it is in your best interest, we will request an extension on your appeal. An extension allows an additional 14 calendar days to complete our review and make a decision. If we ask for an extension, we will mail you a written notice explaining this and tell you what information we need still need. If we don't receive the additional information within this timeframe, we may deny the appeal. You may also request a 14 calendar day extension if you need more time to gather information for the appeal.

Once we have completed the review of your appeal, we will send you a letter with our decision. The letter tells you about our decision and explains how it was made. If we deny your appeal, you may request that AHCCCS look at our decision through a State Fair Hearing. You can request this next step by following the directions we provide in the decision letter.

If you request a State Fair Hearing, you will receive information from AHCCCS about what to do. We will forward your appeal file and related documentation to AHCCCS at the Office of Administrative Legal Services.
If after the State Fair Hearing, AHCCCS will make a decision. If they find that our decision to deny your appeal was correct, you may be responsible for payment of the services you received while your appeal was being reviewed. If AHCCCS decides that our decision on your appeal was incorrect, we will authorize and provide the services promptly.

**Request for expedited resolution**
You or your representative can request an expedited resolution to your appeal if you believe that the timeframe of a standard resolution might jeopardize your life, health or ability to attain, maintain or regain maximum function. We may ask you to send us supporting documentation from your provider. If your provider agrees, we will expedite the resolution of your appeal. We will also automatically expedite the resolution of your appeal if we believe following the standard resolution process could jeopardize your life or health.

If we request that you send us supporting documentation from your provider but do not receive it, your appeal will be resolved within 30 calendar days. When we decide not to expedite the resolution of your appeal, we will notify you promptly. We will attempt to call you and will mail you a written notice within two (2) calendar days that explains this outcome. For more information, please see Request for Standard Appeal in this handbook.

When we expedite the resolution of your appeal, we will resolve your appeal within three (3) business days. Sometimes, we may need more information to make a decision. When this occurs and we believe it is in your best interest, we will request extension on your appeal. An extension allows an additional 14 calendar days to complete our review and make a decision. If we ask for an extension, we will mail you a written notice explaining this and tell you what information we need still need. If we don't receive the additional information within this timeframe, we may deny the appeal. You may also request a 14 calendar day extension if you need more time to gather information for the appeal.

Once we have completed the review your appeal, we will send you a letter with our decision. The letter tells you our decision and explains how it was made. If we deny your appeal, you may request for AHCCCS to review our decision through a State Fair Hearing. You can request this next step by following the directions we provide in the decision letter.

If you request a State Fair Hearing, you will receive information from AHCCCS about what to do. We will forward your appeal file and related documentation to AHCCCS at the Office of Administrative Legal Services.

After the State Fair Hearing, AHCCCS will make a decision. If they find that our decision to deny your appeal was correct, you may be responsible for payment of the services you received while your appeal was being reviewed. If AHCCCS decides that our decision on your appeal was incorrect, we will authorize and provide the services promptly.

**Quick tips about denial, reduction, suspension or termination of services and appeals**
- You will get a letter (Notice of Adverse Benefit Determination) when a service has been denied or changed.
- If you want to ask for a review (appeal) of Mercy Care Plan’s action, follow the directions in your notification letter.
- To request that services be continued, you must file your appeal no later than 10 days from the date of your notification letter, or within the time frame listed in the notification letter.

**Appeals for members determined to have a serious mental illness (SMI)**
A serious mental illness (SMI) is a mental disorder in persons 18 years of age or older that’s severe and persistent. Crisis Response Network, a provider that has a contract with Mercy Care Plan, will make a determination of serious mental illness upon referral or request. Members asking for a determination of
serious mental illness and members who have been determined to have a serious mental illness can appeal the result of a serious mental illness determination.

Crisis Response Network will send you a letter by mail to let you know the final decision on your SMI determination. This letter is called a Notice of Decision. The letter will include information about your rights and how to appeal the decision. If you do not agree with the results of the SMI eligibility determination you may file an appeal. To file an appeal, you can call Crisis Response Network at **1-855-832-2866**.

Members determined to have a serious mental illness may also appeal the following adverse decisions:
- Initial eligibility for SMI services
- A decision regarding fees or waivers
- The assessment report, and recommended services in the service plan or individual treatment or discharge plan
- The denial, reduction, suspension or termination of any service that is a covered service funded through Non Title 19/21 funds
- Capacity to make decisions, need for guardianship or other protective services, or need for special assistance
- A decision is made that the member is no longer eligible for SMI services
- A PASRR determination in the context of either a preadmission screening or an annual resident review, which adversely affects the member

To file an appeal, you must call or send a letter to:

Mercy Care Plan
Appeals Department
4350 E Cotton Center Blvd.
Building D
Phoenix, AZ 85040
**602-453-6098 or 1-800-624-3879**
Fax: **602-230-4503**

If you file an appeal you will continue to get any services you were already getting unless:
- A qualified clinician decides that reducing or terminating services is best for you,
- Or, you agree in writing to reducing or terminating services.

If the appeal is not decided in your favor, Mercy Care Plan may require you to pay for the services you received during the appeal process.

**Grievances**

A grievance is any expression of dissatisfaction related to the delivery of your health care that is not defined as an appeal. This is also called a complaint. You may have a problem with a doctor or felt that office staff treated you poorly. You may have received a bill from your specialist or had difficulty reaching the transportation company for your ride home. A grievance might include concerns with the quality of the medical care you received. Please let us know if you have a concern like this or need help with another problem. The fastest way to report a grievance is to call Member Services. A representative will document your grievance. It is important to provide as much detail as possible. The representative will explain the grievance resolution process and answer any other questions you may have. We may also need to call you back to provide updates or ask you for more information. We want to ensure that you are receiving the care and services you need.
If you prefer to file your grievance in writing, please send your complaint to:

Mercy Care Plan  
Grievance Department  
4350 E Cotton Center Blvd.  
Building D  
Phoenix, AZ 85040

Filing a grievance will not affect your future health care or the availability of services. We want to know about your concerns so we can improve the services that we offer.

- When you call to report a grievance, we will try to help resolve any concerns you have right away. If you submit your grievance in writing, we will send you a letter within five (5) calendar days. The letter acknowledges our receipt of your grievance and explains how you will be notified of the resolution.
- If you submit a grievance over the telephone, we may be able to resolve your concerns and tell you the resolution during the call.
- If your grievance involves concerns about the quality of care or medical treatment you received, we will send the case to our Quality Management department.
- When we cannot resolve your grievance right away, we will let you know and explain the next steps. During our investigation of your concerns, we will work with other departments at Mercy Care Plan as well as your health care provider(s).
- During our investigation, we may need to speak with you again. We may have more questions or we may want to confirm that your immediate needs are met.
- Once the review of your grievance is complete, we will notify you of the resolution.
- If your grievance was reviewed by our Quality Management department, you will get the resolution in writing.
- For other cases, we will call you and explain the resolution to your grievance. If we are unable to reach you, we will send the resolution in writing.
- We are committed to resolving your concerns as quickly as possible and in no more than 90 days from the date you submitted your grievance.

**Grievance/Request for Investigation for members determined to have a serious mental illness (SMI)**  
There is a special process for members determined to have a serious mental illness.

You can file a Grievance/Request for Investigation if you feel:

- Your rights have been violated
- You have been abused or mistreated by staff of a provider
- You have been subjected to a dangerous, illegal, or inhumane treatment environment

You have 12 months from the time that the rights violation happened to file a Grievance. You may file a Grievance by calling Mercy Care Plan Member Services at **602-263-3000** or **1-800-624-3879** (TTY/TDD **711**). Representatives are available Monday through Friday from 7 a.m. to 6 p.m. You may ask staff to help you file your grievance. You can also file a grievance in writing.

To file a written Grievance/Request, mail the form to:

Mercy Care Plan  
Attn: Grievance and Appeals  
4350 E. Cotton Center Blvd.,  
Building D  
Phoenix, AZ 85040
Grievances concerning physical abuse, sexual abuse or a person's death are investigated by AHCCCS. To file a grievance concerning physical abuse, sexual abuse or a person's death, contact:

AHCCCS Office of Grievance and Appeals
801 E. Jefferson
MD 6200
Phoenix, AZ 85034
Phone: 602-364-4575
Fax: 602-364-4591
Deaf or hard of hearing individuals may call the Arizona Relay Service at 711 or 1-800-367-8939 for help contacting AHCCCS

If you file a Grievance/Request for Investigation, the quality of your care will not suffer.

Member rights and responsibilities

As a Mercy Care Plan member, you have rights and responsibilities. These rights are listed below. It is important you read and understand each one. If you have questions, please ask your case manager.

Your rights as a member
- The name of your PCP and/or case manager.
- A copy of the Mercy Care Plan Member Handbook, which includes a description of covered services.
- The right to file a complaint about Mercy Care Plan.
- Information on how Mercy Care Plan provides for after hours and emergency care.
- To request information on the structure and operations of Mercy Care Plan or its subcontractors.
- Information on how Mercy Care Plan pays providers, controls costs and uses services. This information includes whether or not Mercy Care Plan has a Physician Incentive Plan (PIP) and a description of the PIP.
- You have the right to be treated fairly and get covered services without concern about race, ethnicity, national origin (to include those with limited English proficiency), ancestry, marital status, religion, gender, age, mental or physical disability, sexual orientation, genetic information, your ability to pay or speak English.
- The right to know whether stop-loss insurance is required.
- General grievance results and a summary of member survey results.
- Information on how Mercy Care Plan evaluates new technology to include as a covered service.
- Information on how medical decisions can be made for you when you are not able to make them.
- Actions to take if your PCP leaves Mercy Care Plan.
- Your costs to get services/treatments that are not covered by Mercy Care Plan.

Confidentiality and privacy
- You have a right to privacy and confidentiality of your health care information.
- You have a right to talk to health care professionals privately.
- You will find a copy of the “Privacy Rights” notice in your welcome letter. The notice has information on ways in which Mercy Care Plan uses your records, including information on your health plan activities and payments for services. Your health care information is kept private and confidential. It is given out only with your permission or if the law allows it.

Treatment decisions
- You have the right to agree to, or refuse, treatment and to choose other treatment options available to you.
- You can get information on how to get services and authorizations for services.
- You can choose a Mercy Care Plan PCP to plan your health care.
• You can change your PCP.
• Within the limits of applicable regulations, Mercy Care Plan staff may help manage your health care by working with you, community and state agencies, schools, and your doctor.
• You can talk with your PCP to get complete and current information about your health care and condition. This information helps you and/or your family understand your condition and be a part of making decisions about your health care.
• You have the right to information on medical procedures you will have and who will perform them.
• You have the right to a second opinion within the Mercy Care Plan network. You can request a second opinion from a doctor outside of Mercy Care Plan's network, at no cost to you only if there is not adequate in network coverage.
• You can refuse care from a doctor to whom you were referred, and you can ask for a different doctor.
• You can choose someone to be with you for treatments and exams.
• You can have a female in the room for breast and pelvic exams.
• You have the right to know treatment choices or types of care available to you and the benefits and/or drawbacks of each choice.
• You have the right to have another caregiver help you within two (2) hours following your request for help.
• You can say, “no” to treatments, services and PCPs. You have the right to be informed about what may happen by not having the treatment. Your eligibility or medical care does not depend on your agreement to follow a treatment plan.
• You can say, “no” to tasks that a provider may ask you to perform that are not part of your care plan.
• You can say, “no” to medications or restraints, except for times when your doctor thinks these actions are needed to protect you or others from harm.
• You can ask Mercy Care Plan to amend or correct your medical records.
• You can transfer or leave a long term services and supports home because of medical reasons, for your own good or the good of others, or for not paying.
• You have the right to be provided with information about creating advance directives. Advance directives tell others how to make medical decisions for you if you are not able to make them for yourself.

Medical records requests
• At no cost to you, you have the right to annually request and receive one copy of your medical records and/or inspect your medical records. You may not be able to get a copy of medical records if the record includes any of the following information: psychotherapy notes put together for a civil, criminal or administrative action; protected health information that is subject to the Federal Clinical Laboratory Improvements Amendments of 1988; or protected health information that is exempt due to federal codes of regulation.
• Mercy Care Plan will reply to your request within 30 days. Mercy Care Plan's reply will include a copy of the requested record or a letter denying the request. The written denial letter will include the basis for the denial and information on ways to get the denial reviewed.
• You have the right to request an amendment to your medical records. Mercy Care Plan may ask that you put this request in writing. If the amendment is made, whole or in part, we will take all steps necessary to do this in a timely manner and let you know about changes that are made.
• Mercy Care Plan has the right to deny your request to amend your medical records. If the request is denied, whole or in part, then Mercy Care Plan will provide you with a written denial within 60 days. The written denial includes the basis for the denial, notification of your right to submit a written statement disagreeing with the denial and how to file the statement.

Reporting your concerns
• Tell Mercy Care Plan about any complaints or issues you have with your health care services.
• You may file an appeal with Mercy Care Plan and get a decision in a reasonable amount of time.
You can give Mercy Care Plan suggestions about changes to policies and services.
You have the right to report your concerns about Mercy Care Plan.

**Personal rights**
- If you live in a nursing facility or an alternative residential facility, you may choose to share a room with your spouse when appropriate.
- If you choose, you may remain in your home.
- You can manage your own money or choose someone you trust to manage your money on your behalf.
- You can use your rights as a citizen.
- You can choose to speak or not to speak with people.
- If you live in a nursing facility or an alternative residential facility, you can keep and use your personal clothing and belongings when there is space and no medical reasons not to.
- You have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- You have the right to receive information on beneficiary and plan information.

**Respect and dignity**
- You have the right to be treated with respect and with due consideration for your dignity and privacy.
- You have the right to participate in decisions regarding your health care, including the right to refuse treatment.
- You can get quality medical services that support your personal beliefs, medical condition and background in a language you understand. You have the right to know about other providers who speak languages other than English.
- You can get interpretation services if you do not speak English. You can get sign language services if you are deaf or have difficulty hearing.
- You can get materials in alternative formats (such as large type or audio recording) or in another language.
- Mercy Care Plan will inform you in writing when any of your health care services are reduced, suspended, terminated or denied. You must follow the instructions in your notification letter.
- The type of information about your treatment is available to you in a way that helps your understanding given your medical condition.

**Emergency care and specialty services**
- If you have an emergency, you can get emergency health care services without the approval of your PCP or Mercy Care Plan. You may go to any hospitals, emergency rooms or other settings for emergency care.
- You may get behavioral health services without the approval of your PCP or Mercy Care Plan.
- You can see a specialist with a referral from your PCP.

**Fraud and abuse**

**Fraud**
Committing fraud or abuse is against the law. Your health benefits are given to you based on your health and financial status. You should not share your benefits with anyone. If you misuse your benefits, you could lose your AHCCCS benefits. AHCCCS may also take legal action against you. If you think a person, member or provider is misusing the program, please call Member Services or AHCCCS. For a complete listing of provider actions that can lead to fraud/abuse, please go to definitions section - Provider Fraud/Abuse. Fraud is a dishonest act done on purpose.

Examples of member fraud are:
- Letting someone else use your Mercy Care Plan ID card
- Getting prescriptions with the idea of abusing or selling drugs
• Changing information on your Mercy Care Plan ID card
• Changing information on a prescription

Examples of provider fraud are:
• Billing for services that were not given
• Ordering services that are not medically necessary
• Referring members to an emergency room or other service when it is not medically necessary

Abuse
Abuse can mean providers that take actions resulting in needless costs to AHCCCS. This includes providing medical services that are not required. It may also mean the provider does not meet required health care standards. Abuse can also include member actions that result in extra cost to AHCCCS.

Abuse means provider practices that are inconsistent with sound financial, business, or medical practices. This can result in an unnecessary cost to the Medicaid program. Abuse can also be a refund for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes member practices that result in unnecessary cost to the Medicaid program.

Reporting
If you think a person, member or provider is misusing the program, please let us know.
• Mercy Care Plan Fraud Hotline: 1-800-810-6544
• AHCCCS Fraud Reporting: 602-417-4193 or 1-888-487-6686

Tobacco cessation
Do you use tobacco? Quitting tobacco is one of the best things that you can do for your health. Your Mercy Care Plan case managers can talk to you about quitting. If you get medication and coaching, you can double your success of being able to quit. You can get your medication from your PCP. Your case manager or PCP can also refer you to Arizona Smokers Helpline (ASHLine) for coaching and resources to help quit tobacco. You do not need a referral to ASHLine. You can call them directly. Arizona Smokers Helpline (ASH) can be reached at 1-800-556-6222, or visit www.ASHline.org.

In addition to ASHLine, there are other resources available for you. For more information on quitting tobacco, go to Tobacco Free Arizona at http://azdhs.gov/prevention/tobacco-chronic-disease/tobacco-free-az. Tobacco Free Arizona is a program to help Arizonans know the risks of tobacco use and resources for quitting.

Decisions about your health care
Living wills and other health care directives for adult members
There may be a time when you cannot make decisions about your health care. If this happens, doctors will follow your health care directive. Health care directives are also called advance directives. Advance directives are documents that you fill out to tell doctors what type of care you want. They protect your right to refuse health care you do not want, or to request care you do want.

There are four (4) kinds of advance directives. Mercy Care Plan strongly encourages you to have one or more of these papers filled out. Mercy Care Plan has written policies to make sure your wishes are followed. You should get help writing your living will and/or health care directives. If you are not sure who to call for help, ask your case manager or doctor for help.
The four (4) kinds of health care directives include:

1. **Living will** - a paper that tells doctors what kinds of services you do or do not want if you become ill and may die. In your living will, you might tell doctors if you want to be kept alive with machines or fed through tubes if you cannot eat or drink on your own.

2. **Durable medical power of attorney** - a paper that lets you choose a person you trust to make decisions about your health care when you cannot.

3. **Mental health care power of attorney** - names a person to make mental health care decisions if you are found incapable to do so.

4. **Pre-hospital medical care directive** - states your wishes about refusing certain life-saving emergency care given outside a hospital or in a hospital emergency room. You must complete a special orange form.

**Making your advance directives legal**

For a medical power of attorney, you must choose someone you trust to be your agent. Your agent is the person who will make decisions about your health care if you cannot yourself. He/she can be a family member or a close friend. To make an advance directive legal, you must either:

1. Sign and date it in front of another person, who also signs it. This person cannot:
   - Be related to you by blood, marriage, or adoption
   - Have a right to receive any of your personal and private property
   - Be appointed as your agent
   - Be involved with the paying of your health care

   **OR**

2. Sign and date it in front of a notary public. The notary public cannot be your agent or any person involved with the paying of your health care.

If you are too ill to sign your medical power of attorney, you may have another person sign for you.

**What to do after you complete writing your advance directives**

- Keep your original signed papers in a safe place.
- Give copies of the signed papers to your case manager, doctor(s), hospital, and anyone else who might become involved in your health care. Talk to these people about your wishes concerning health care.
- If you want to change your papers after they have been signed, you must fill out new ones. You should make sure you give a copy of the new paper to all the people who already have a copy of the old one.
- Be aware that your directives may not be effective in the event of a medical emergency.
- You can also have advance directives registered with the Arizona Registry at www.azsos.gov/services/advance-directives.

**Common questions**

**Q.** What should I do if I lose my member ID card or don't get one?
A. Call Mercy Care Plan Member Services. Member Services at 602-263-3000 or 1-800-624-3879 (TTY/TDD 711).

**Q.** How will I know the name of my PCP?
A. Mercy Care Plan sends a welcome letter to you. This welcome letter has the name and telephone number of your PCP.

**Q.** Can I change my PCP?
A. Yes. Please call Mercy Care Plan Member Services at 602-263-3000 or 1-800-624-3879 (TTY/TDD 711).
Q. How can I check the status of my authorization?
A. For a quick and easy status check, look at your personal records on our secure website: MercyOneSource. Go to www.mercycareplan.com, and then select MercyOneSource in the upper right corner. Also, your PCP will call Mercy Care Plan to check status of your authorizations. Your PCP will let you know the status.

Q. How do I know which services are covered?
A. This handbook explains services that are covered and not covered. Look under the section that applies to you. You may also ask your doctor or Mercy Care Plan Member Services. If you have access to the Internet, you can find more information about covered and not covered services on our website at https://www.mercycareplan.com/members/mcpltc/information.

Q. What should I do if I get a bill?
A. If you get a bill, call the health care provider who billed you and give them your Mercy Care Plan information. If they continue to bill you, please call Mercy Care Plan Member Services for help.

Q. I need help getting to my doctor. What can I do?
A. Check first with neighbors, friends or relatives for a ride. If you are not able to find a ride, please call Mercy Care Plan Member Services at least three (3) days before your appointment. If you need to go to urgent care, you may call Member Services the same day to set up a ride. Please note, there is a three-hour wait for same day rides. Member Services is available Monday through Friday, 7 a.m. to 6 p.m. at 602-263-3000 or 1-800-624-3879 (TTY/TDD 711).

Q. What hospitals can I use?
A. Mercy Care Plan uses many hospitals. You can find a list of hospitals in the Mercy Care Plan provider directory. There is a searchable provider directory on the Mercy Care Plan website at www.mercycareplan.com. Select “Find a Provider,” then you can search by provider or by hospital. You can go to any hospital for emergency care. You can get emergency health care services without the approval of your PCP or Mercy Care Plan when you have a medical emergency. You may go to any emergency room or other settings for emergency care. If you have to be hospitalized for any reason, you may go to the hospital to which your doctor refers you.

Q. What is an emergency?
A. An emergency is a medical condition that could cause serious health problems or even death if not treated immediately.

Q. Does Mercy Care Plan have urgent care centers?
A. Yes. You can find an urgent care center using the searchable provider directory on the Mercy Care Plan website at www.mercycareplan.com. Select “Find a Provider,” then click on “Mercy Care Plan/Mercy Care Plan Long to Care.” Select your health plan, enter the city, state and ZIP code, and select “Urgent Care Facility” under “Specialty.”
Resources

Community resources

AHCCCS (Arizona Health Care Cost Containment System)
801 E. Jefferson St.
Phoenix, AZ 85034
602-417-4000

www.healthearizonaplus.gov
This website helps connect individuals and families to coverage, benefits and services.

Women, Infants and Children (WIC) Program
WIC serves pregnant women, infants, and children under five years old. WIC provides food, breastfeeding education, and information on healthy diet.
Website: azdhs.gov/prevention/azwic
Find out if you’re eligible at azdhs.gov/prevention/azwic/families/index.php#eligibility
Find a clinic near you: clinicsearch.azbnp.gov

Arizona Department of Health Services
www.azdhs.gov/index.php
150 N. 18th Ave., Ste. 310
Phoenix, AZ 85007
602-542-1025

Nurse Family Partnership
The Nurse Family Partnership is a program for first time mothers who are less than 28 weeks pregnant in North or South Phoenix or Tucson. A registered nurse will come to the home of a pregnant member. They will help to make sure that she has a healthy pregnancy. There is no cost for this service for Mercy Care Plan's pregnant members.

Phoenix Nurse-Family Partnership/Southwest Human Development
2850 N. 24th St.
Phoenix, AZ 85008
602-224-1740

Tucson Nurse Family Partnership/Casa de los Niños
1101 N. 4th Ave.
Tucson, AZ 85705
520-624-5600 ext. 506
Healthy Families
This program helps mothers have a healthy pregnancy and also helps with child development, nutrition, safety and other things. A community health worker will go to the pregnant member’s home to give her information and help with any concerns that she might have. The program starts while the member is pregnant and can continue through the time that the baby is 5 years old!

Maricopa County
602-427-4725

Pima County
520-321-3754

Pinal County
520-518-5292

Teen Outreach Pregnancy Services
Teen Outreach Pregnancy Services (TOPS) is a program designed for pregnant and parenting teens. The nurses and social workers understand the challenges teens face and help to make sure the pregnant mother and baby are healthy. There are classes about having a healthy pregnancy, childbirth and parenting. The classes are for teens only! Services also include helping teen moms get things needed for pregnancy and new baby.

West Valley
6610 N. 47th Ave., Ste. 12
Glendale, AZ 85301
623-334-1501

East Valley
931 E. Southern Ave., Ste.111
Mesa, AZ 85204
480-668-8800

Tucson Area
3024 E. Ft. Lowell Rd
Tucson, AZ 85716
520-888-2881

Gila County
Call 928-275-0494

Arizona Suicide Prevention Coalition
http://www.azspc.org/

Mentally Ill Kids in Distress (MIKID)
http://www.mikid.org
Arizona Postpartum Warm Line
www.psiarizona.org
Providing support for new mothers and families and improving access to postpartum screenings, treatment options, and resources.
1-888-434-MOMS
(1-888-434-6667)

Arizona Department of Economic Security
1-888-737-7494

www.AZLinks.gov
AZ Links is the website of Arizona's Aging and Disability Resource Consortium (ADRC). AZ Links helps Arizona seniors, people with disabilities, caregivers and family members locate resources and services.
- Can assist you in identifying your needs and getting connected to an agency that can answer your questions.
- Link to a wide range of activities, such as reviewing Medicare/Medicaid benefits, reading about what's new in health care, searching for job opportunities, caregiver respite, housing options, and more.

Area Agency on Aging Region 1
1366 E. Thomas Rd., Ste. 108
Phoenix, AZ 85014
602-264-2255 or 1-888-783-7500
www.aaaphx.org

Information for caregivers
24-hour Senior Help Line: 602-264-HELP (4357)

Alzheimer's Association Central Arizona Regional Office
The Alzheimer's Association is the leading voluntary health organization in Alzheimer care, support and research. Resources include: care finder, help line, library, workshops and support groups, and tips for caregivers. AZ Links is the website of Arizona's Aging and Disability Resource Consortium (ADRC). AZ Links helps Arizona seniors, people with disabilities, caregivers and family members locate resources and services.

1028 E. McDowell Rd.
Phoenix, AZ 85006
602-528-0545 or 1-800-272-3900
ALZ.org/dsw

Arizona Head Start
www.azheadstart.org
Head Start is a great program that gets preschoolers ready for kindergarten. Preschoolers enrolled in Head Start will get healthy snacks and meals too. Head Start offers these services and more at no cost to you. To locate a Head Start program in your area visit; www.azheadstart.org/head-start-programs.php
If you live in one of the cities or counties below, call to find a facility near you.

Gila or Pinal County: 520-723-5321
Phoenix: 602-262-4040 or 602-506-5911
Maricopa County (East Valley): 480-464-9669
Maricopa County (West Valley): 623-486-9868
Other areas within Maricopa County or if you have questions: 602-262-4040 or 602-506-5911
Pima County: 520-882-0100
Arizona Early Intervention Program (AzEIP): www.azdes.gov/AzEIP
The Arizona Early Intervention Program (AzEIP, pronounced Ay-zip), helps families of children with disabilities or developmental delays age birth to three years old. They provide support and can work with their natural ability to learn. To get help or learn more about AzEIP resources, call Mercy Care Plan and ask for the Mercy Care Plan AzEIP coordinator.

3839 N. 3rd St., Ste.304
Phoenix, AZ 85012
602-532-9960

Child and Family Resources
www.ChildFamilyResources.org
1-800-308-9000

Programs include:
• Child Care Resource & Referral, where parents can call to get a list of child care centers
• The Center for Adolescent Parents where teen mothers can earn their high school diploma or GED while receiving no-cost, on-site child care
• In-home support for families with babies under the age of 3 months

2830 W. Glendale Ave.
Phoenix, AZ 85051
602-234-3941

2800 E. Broadway Blvd.
Tucson, AZ 85716
520-881-8940

1115 E. Florence Boulevard, Suite M
Casa Grande, AZ 85122
520-518-5292

Nutrition Assistance (formerly the Food Stamp Program)
Supporting families to prevent under-nutrition in Arizona.
www.azdes.gov/nutrition_assistance
1-855-432-7587

Community Information and Referral
Community I&R is a call center that can help you find many community services.
• Food banks, clothes, shelters, help to pay rent and utilities
• Health care, help when you or someone else is in trouble, support groups, counseling, help with drug or alcohol problems
• Financial help, job training, transportation, education programs
• Adult day care, meals on wheels, respite care, home health care, transportation, homemaker services
• Counseling, help with learning, protective services
Call 211 for information on this program or go to www.cir.org.
Advocacy

There are groups you can contact who will act as an advocate for you. Health advocacy involves direct service to you and your families, which can help promote health and access to health care. An advocate is anyone who supports and promotes your rights. There are many advocacy resources listed in this section.

There are many advocacy resources listed below.

Behavioral health advocacy
Arizona has a number of advocacy groups and resources available to assist you with a variety of your behavioral health needs. These include:

- Mental Health America of Arizona: 602-214-9507
- National Domestic Violence Hotline: 1-800-799-7233
- Arizona Coalition to End Sexual & Domestic Violence: 602-279-2900 or 1-800-782-6400
- Childhelp National Child Abuse Hotline: 1-800-422-4453

Arizona Center for Disability Law Mental Health
www.acdl.com/mentalhealth.html
The Arizona Center for Disability Law is a federally designated Protection and Advocacy System for the State of Arizona. Protection and Advocacy Systems throughout the United States ensure that the human and civil rights of persons with disabilities are protected. Protection and Advocacy Systems can pursue legal and administrative remedies on behalf of persons with disabilities to ensure the enforcement of their constitutional and statutory rights.

- Arizona Center for Disability Law, Phoenix location: 602-274-6287 or 1-800-927-2260
- Arizona Center for Disability Law, Tucson location: 520-327-9547 or 1-800-922-1447

NAMI Arizona (National Alliance on Mental Illness)
www.namiaz.org
NAMI Arizona has a helpline for information on mental illness, referrals to treatment and community services, and information on local consumer and family self help groups throughout Arizona. NAMI Arizona provides emotional support, education and advocacy to people of all ages who are affected by mental illness.

- National Alliance on Mental Illness (NAMI): 602-244-8166
- National Alliance on Mental Illness of Southern Arizona: 520-622-5582

Special assistance for members with serious mental illness (SMI)
The office of Human Rights will help you if you have a serious mental illness. They can help you understand and exercise your rights. They will help you protect your rights and advocate for yourself.

- Maricopa, Pinal or Gila Counties: 602-364-4585 or 1-800-421-2124
- Pima, Santa Cruz, Cochise, Graham, Greenlee, Yuma or La Paz Counties: 520-770-3100 or 1-877-744-2250
- Mohave, Coconino, Yavapai, Navajo or Apache Counties: 602-364-4577 or 1-800-421-2124

Long Term Services and Supports (LTSS) advocacy

Centers for Independent Living
Ability 360 - Maricopa
5025 E. Washington, Ste. 200
Phoenix, AZ 85034
602-256-2246

Direct Center for Independence
1001 N. Alvernon Way
Tucson, AZ 85711
520-624-6452
Disability 101
This website gives you tools and information on health coverage, benefits and employment.
https://az.db101.org

Low income housing
This website gives you information about low income housing.
http://www.lowincomehousing.us/

Pima Council on Aging
8467 E. Broadway
Tucson, AZ 85710
Pima Council on Aging Helpline: 520-790-7262
Medicare Information: 520-546-2011
Administration/Business: 520-790-0504
Fax: 520-790-7577

Pinal-Gila Council for Senior Citizens
8969 W. McCartney Road
Casa Grande, AZ 85194
520-846-2758

The following organizations provide health care directive forms and information.

Health Care Decisions
1510 E. Flower St
Phoenix, AZ 85014
602-222-2229
www.Hcdecisions.org

Arizona Attorney General's Office - Phoenix
1275 W. Washington
Phoenix, AZ 85007
602-542-5763 or 1-800-352-8431
www.azag.gov

Arizona Attorney General's Office - Tucson
400 W. Congress, South Bldg., Ste. 315
Tucson, AZ 85701
520-628-6504

Arizona Attorney General's office - outside Phoenix and Tucson
1-800-352-8431

Department of Economic Security (DES)
Division of Aging and Adult Services
1789 W. Jefferson, Site Code 950A
Phoenix, AZ 85007
602-542-4446
www.azdes.gov/DAAS

Your local Area Agency on Aging and Senior Center may also have forms and information.

National organizations

AARP
601 “E” Street, N.W., Ste A1-200
Washington, D.C. 20049
1-888-687-2277
For an AARP office in Arizona, go to www.aarp.org/states/az/

The following organizations provide information and answer questions about health care directives and other related legal matters.

Arizona Senior Citizens Law Project
1818 S. 16th St.
Phoenix, AZ 85034
602-252-6710

Community Legal Services
305 S. 2nd Ave.
P.O. Box 21538
Phoenix, AZ 85036
602-258-3434 or 1-800-852-9075
www.clsaz.org

MESA
20 W. First St., Ste. 101
Mesa, AZ 85201
480-833-1442

www.mercycareplan.com
Member Services 602-263-3000 or 1-800-624-3879 (TTY/TDD 711)
Monday - Friday, 7 a.m. to 6 p.m.
If you lose eligibility resources

We want you to be able to get medical care if you do lose your AHCCCS eligibility. Below is a list of clinics that offer low cost or no cost medical care. Call the clinics to find out about services and costs. If you have questions or need help call Mercy Care Plan Member Services.

LOW COST/SLIDING SCALE HEALTH CARE

GILA COUNTY

Globe
Canyonlands Healthcare
5860 South Hospital Drive, Suite 102
Globe, AZ 85501
928-402-0490

Payson
North Country Healthcare
708 S. Coeur D Alene Lane
Payson, AZ 85541
928-468-8610

Payson Christian Clinic
701 S. Ponderosa, Suite D
Payson, AZ 85541
928-468-2209

Pima Council on Aging
8467 E. Broadway
Tucson, AZ 85701
520-790-7262

Pinal-Gila Council for Senior Citizens
8969 W. McCartney Road
Casa Grande, AZ 85194
520-846-2758

Southern Arizona Legal Aid (SALA)
Administration Building
2343 E. Broadway Blvd., Ste. 200
Tucson, AZ 85719
520-623-9465 or 1-800-640-9465

Southern Arizona Legal Aid (SALA)
766 N. Park Avenue
Casa Grande, AZ 85222
520-316-8076 or 1-877-718-8086

Tohono O'odham Legal Services
A division of Southern Arizona Legal Aid
520-623-9465, Ext. 4122 or 1-800-248-6789

White Mountain Legal Aid
A division of Southern Arizona Legal Aid
5658 Highway 260, Suite 15
Lakeside, AZ 85929
928-537-8383
1-800-658-7958
MARICOPA COUNTY

Adelante Healthcare
Avondale
Coronado Professional Plaza
3400 Dysart Rd, Ste F-121
Avondale, AZ 85392
1-877-809-5092

Buckeye
306 E. Monroe Ave.
Buckeye, AZ 85326
1-877-809-5092

Gila Bend
100 N. Gila Blvd.
Gila Bend, AZ 85337
1-877-809-5092

Mesa
1705 W. Main St.
Mesa, AZ 85201
1-877-809-5092

Phoenix
7725 N. 43rd Ave, Ste. 510
Phoenix, AZ 85051
1-877-809-5092

Surprise
15351 W. Bell Rd.
Surprise, AZ 85374
1-877-809-5092

Wickenburg
811 N. Tegner St, Ste. 113
Wickenburg, AZ 85390
1-877-809-5092

HonorHealth Desert Mission Healthcare Center (formerly John C. Lincoln Community Health Center)
9201 N. 5th St.
Phoenix, AZ 85020
602-331-5792

Maricopa Integrated Health System
McDowell Healthcare Center
1101 N. Central Ave., 2nd Floor, Ste. 201
Phoenix, AZ 85004
602-344-6550

Sunnyslope Family Health Center
934 W. Hatcher Rd.
Phoenix, AZ 85021
602-344-6300

Comprehensive Health Center
2525 Roosevelt St.
Phoenix, AZ 85008
602-344-1015

Guadalupe Family Health Center
5825 E. Calle Guadalupe
Guadalupe, AZ 85283
480-344-6000

South Central Family Health Center
33 W. Tamarisk St.
Phoenix, AZ 85041
602-344-6400

Mountain Park Health Center – Baseline
635 E. Baseline Rd.
Phoenix, AZ 85042
602-243-7277

Maryvale Family Health Center
4011 N. 51st Ave.
Phoenix, AZ 85031
623-344-6900

Maricopa County Health Care for the Homeless
220 S. 12th Ave.
Phoenix, AZ 85007
602-372-2100

Chandler Family Health Center
811 S. Hamilton St.
Chandler, AZ 85225
480-344-6100

El Mirage Family Health Center
12428 W. Thunderbird Rd.
El Mirage, AZ 85335
623-344-6500
<table>
<thead>
<tr>
<th>Location</th>
<th>Address</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avondale Family Health Center</td>
<td>950 E. Van Buren St.</td>
<td>623-344-6800</td>
</tr>
<tr>
<td>Glendale Family Health Center</td>
<td>5141 W. Lamar St.</td>
<td>623-344-6700</td>
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<tr>
<td>Mesa Family Health Center</td>
<td>59 S. Hibbert</td>
<td>480-344-6200</td>
</tr>
<tr>
<td>Seventh Avenue Family Health Center</td>
<td>1205 S. 7th Ave.</td>
<td>602-344-6600</td>
</tr>
<tr>
<td>Mountain Park Health Centers Tempe Community Health Center</td>
<td>1492 S. Mill Ave., Ste. 312</td>
<td>602-243-7277</td>
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<tr>
<td>Mountain Park Health Center - Goodyear</td>
<td>140 N. Litchfield Rd.</td>
<td>602-243-7277</td>
</tr>
<tr>
<td>Mountain Park Health Center - East Phoenix</td>
<td>3830 E. Van Buren St.</td>
<td>602-243-7277</td>
</tr>
<tr>
<td>Native American Community Health Center, Inc.</td>
<td>4041 N. Central Ave.</td>
<td>602-279-5262</td>
</tr>
<tr>
<td>Armadillo Pediatrics</td>
<td>515 W. Buckeye Rd., Ste. 402</td>
<td>602-257-9229</td>
</tr>
<tr>
<td>OSO Medical</td>
<td>378 N. Litchfield Rd., Ste. 116</td>
<td>623-925-2622</td>
</tr>
<tr>
<td>St. Vincent De Paul /Virginia G. Piper Medical &amp; Dental Clinic</td>
<td>420 W. Watkins Rd.</td>
<td>602-261-6868</td>
</tr>
<tr>
<td>Desert Senita Community Health Center</td>
<td>410 N. Malacate St.</td>
<td>520-387-4500</td>
</tr>
<tr>
<td>El Rio Community Health Centers</td>
<td>Congress Health Center</td>
<td>520-670-3909</td>
</tr>
<tr>
<td>El Rio Northwest Health Center</td>
<td>320 W. Prince Rd.</td>
<td>520-670-3909</td>
</tr>
<tr>
<td>El Rio Southwest Internal Medicine</td>
<td>1510 W. Commerce Ct.</td>
<td>520-670-3909</td>
</tr>
<tr>
<td>El Rio Broadway Clinic</td>
<td>1101 E. Broadway Blvd.</td>
<td>520-670-3909</td>
</tr>
<tr>
<td>El Rio Health Center</td>
<td></td>
<td>520-573-0096</td>
</tr>
<tr>
<td>Marana Healthcare (MHC)- Freedom Park Health Center</td>
<td>5000 E. 29th St.</td>
<td>520-790-8500</td>
</tr>
<tr>
<td>MHC - Keeling Health Center</td>
<td>435 E. Glenn St.</td>
<td>520-616-1560</td>
</tr>
</tbody>
</table>
**MHC - Ortiz Community Health Center**
12635 W. Rudasill Rd.
Tucson, AZ 85743
520-682-3777

**MHC - Flowing Wells Family Health Center**
1323 W. Prince Rd.
Tucson, AZ 85709
520-887-0800

**MHC - East Side Health Center**
8181 E. Irvington Rd.
Tucson, AZ 85730
520-574-1551

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**PINAL COUNTY**

**Apache Junction Clinic**
575 N. Idaho Road, Suite 301
Apache Junction, AZ 85119
1-866-960-0633

**Casa Grande Clinic**
1729 N. Trekell Road, Suite 120
Casa Grande, AZ 85122
1-866-960-0633

**Coolidge Clinic**
119 W. Central
Coolidge, AZ 85128
1-866-960-0633

**Eloy Clinic**
302 E. 5th
Eloy, AZ 85131
1-866-960-0633

**Kearny Clinic**
355 Alden Road
Kearny, AZ 85137
1-866-960-0633

**Mammoth Clinic**
110 Main Street
Mammoth, AZ 85618
1-866-960-0633

**Maricopa Clinic**
41600 W. Smith-Enke Boulevard, Building 15
Maricopa, AZ 85138
1-866-960-0633

**Oracle Clinic**
1870 W. American Avenue
Oracle, AZ 85623
1-866-960-0633

**San Manuel Clinic**
Held at Sun Life Clinic
23 S. McNab Parkway
San Manuel, AZ 85631
1-866-960-0633

**San Tan Clinic**
36235 N. Gantzel Road
San Tan Valley, AZ 85142
1-866-960-0633

**Superior Clinic**
60 E. Main Street
Superior, AZ 85713
1-866-960-0633
Low-fee dental services

GILA COUNTY

Copper Vista Dental Care
1450 South Street, Suite 3
Globe, AZ 85501
928-4525-8175

Canyonlands Healthcare
5860 S. Hospital Drive, Suite 120
Globe, AZ 85501
928-402-0491

MARICOPA COUNTY

Mountain Park Dental Clinic (5 locations)
602-243-7277 (scheduling all locations)
www.MPHC-AZ.org

1492 S. Mill Ave., Ste. 312
Tempe, AZ 85281

3830 E. Van Buren St.
Phoenix, AZ 85008

635 E. Baseline Rd.
Phoenix, AZ 85042

6601 W. Thomas Rd.
Phoenix, AZ 85033

140 N. Litchfield Rd.
Goodyear, AZ 85338

Native American Community Health Center
4041 N. Central Ave.
Building C
Phoenix, AZ 85012
602-279-5262
www.NativeHealthPhoenix.com

Phoenix College Clinic
1202 W. Thomas Rd.
Phoenix, AZ 85013
602-285-7323
www.pc.maricopa.edu

St. Vincent de Paul
420 W. Watkins St.
Phoenix, AZ 85002
602-261-6868
www.StVincentdePaul.net

PIMA COUNTY

El Rio Health Center
El Rio Dental Congress
839 W. Congress St.
Tucson, AZ 85745
520-670-3909
www.elrio.org

El Rio Northwest Dental Center
340 W. Prince Rd.
Tucson, AZ 85705
520-670-3909
www.elrio.org

El Rio Southwest Dental Center
1530 W. Commerce Ct.
Tucson, AZ 85746
520-670-3909
www.elrio.org

Pima Community College
Hygiene School
2202 W. Anklam Rd.
Science Building K, Room K-212
Tucson, AZ 85709
520-206-6090
www.pima.edu

Desert Senita Health Center
410 Malacate St.
Ajo, AZ 85321
520-387-5651
www.ajohealthcenter.org

PINAL COUNTY

Sun Life Family Health Center
865 N. Arizona Road
Casa Grande, AZ 85122
520-381-0381
www.sunlifefamilyhealth.org
Definitions

**Action** - an action by Mercy Care Plan means:
- The denial or limited authorization of a service you or your doctor have requested
- The reduction, suspension or ending of an existing service
- The denial of payment for a service, either all or part
- Failure to provide services in a timely manner
- Failure to act within certain timeframes for grievances and appeals
- Denial of a rural member's request to get services out of the network when Mercy Care Plan is the only health plan in the area
- Denial of an increase in services authorized by your case manager

**AHCCCS** - (Arizona Health Care Cost Containment System) is the state agency that manages the Medicaid program in Arizona using federal and state funds. AHCCCS contracts with managed care health plans and program contractors to deliver medical and long-term care services to eligible members.

**ALTCS** - (Arizona Long Term Care System) is the AHCCCS program that provides Medicaid services to elderly and physically disabled members. Mercy Care Plan is contracted with ALTCS to provide long-term care services to eligible members.

**Appeal** - the request for review of an adverse benefit determination.

**Appeal resolution** - the written determination by Mercy Care Plan about an appeal.

**Authorization** - an approval that you need from your doctor and/or Mercy Care Plan before getting other health care services including, but not limited to, laboratory and radiology tests and visits to specialists and other health care providers (see referral).

**Copayment** - a monetary amount that the member pays directly to a provider at the time covered services are rendered, as defined in 9 A.A.C. 22, Article 7.

**Durable Medical Equipment (DME)** - equipment that provides therapeutic benefits; is designed primarily for a medical purpose; is ordered by a physician/provider; is able to withstand repeated use; and is appropriate for use in the home.

**Emergency** - a medical condition that might cause serious health problems or even death if it is not treated immediately.

**Emergency medical condition** - medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: a) placing the patient's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, b) serious impairment to bodily functions, or c) serious dysfunction of any bodily organ or part [42 CFR 438.114(a)].

**Emergency medical transportation** - emergency transportation, including transportation initiated by an emergency response system such as 911, may be provided by ground, air or water ambulance to manage member's emergency medical condition at an emergency scene and transport the member to the nearest appropriate medical facility.

**Emergency room care** - includes medical services that evaluate and help stabilize a patient during an emergency medical condition.
**Emergency services** - covered inpatient and outpatient services provided after the sudden onset of an emergency medical condition as defined above. These services must be furnished by a qualified provider, and must be necessary to evaluate or stabilize the emergency medical condition [42 CFR 438.114(a)].

**Excluded services** - services not covered under the State Plan or the 1115 Waiver, including but not limited to, services that are above a prescribed limit, experimental services, or services that are not medically necessary.

**Expedited appeal** - a request to have the review of an action completed within 3 business days.

**Grievance** - a member's expression of dissatisfaction with any matter, other than an adverse benefit determination.

**Grievance system** - a system that includes the following processes: member grievances and appeals, provider claim disputes and access to the State Fair Hearing system.

**Habilitation services and devices** - the process by which a person is assisted to acquire and maintain those life skills that enable the person to cope more effectively with personal and environmental demands and to raise the level of the person's physical, mental and social efficiency (A.R.S. §36-551 (18)).

**Health insurance** - coverage against expenses incurred through illness or injury of the person whose life or physical well-being is the subject of coverage.

**Home health care** - nursing services, home health aide services, therapy services, and medical supplies, equipment, and appliances as described in 42 CFR 440.70 when provided to a member at his place of residence and on his or her physician's orders as part of a written plan of care [42 CFR 440.70].

**Hospice services** - palliative and support care for members who are certified by a physician as being terminally ill and having six months or less to live.

**Hospitalization** - admission to, or period of stay in, a health care institution that is licensed as a hospital as defined in R9-22-101.

**Hospital outpatient care** - any type of medical or surgical care performed at a hospital that your doctor does not expect will be an overnight hospital stay. In some cases, you may stay overnight in the hospital, but not be admitted as an inpatient (this would be considered outpatient service).

**Medically Necessary** - as defined in 9 A.A.C. 22 Article 101. Medically necessary means a covered service provided by a physician or other licensed practitioner of the health arts within the scope of practice under State law to prevent disease, disability or other adverse conditions or their progression, or to prolong life.

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

**Non-participating provider** - a person or entity that provides services as prescribed in A.R.S. §36-2901 who does not have a subcontract with an AHCCCS Contractor.

**Notice of Adverse Benefit Determination** - a written notice to the member regarding an action taken by Mercy Care Plan.

**Participating provider** - a person or entity who participates in the contractors network.

**Physician services** - medical assessment, treatments and surgical services provided by licensed allopathic or osteopathic physicians within the scope of practice.
Plan - a complete written description of all covered health services and other informal supports which includes individualized goals, family support services, care coordination activities and strategies to assist the member in achieving an improved quality of life.

Preauthorization - process by which the Administration or contractor, whichever is applicable, authorizes, in advance, the delivery of covered services based on factors including but not limited to medical necessity, cost effectiveness, compliance with this Article and any applicable contract provisions. Prior authorization is not a guarantee of payment (A.A.C. R9-22-101).

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

Prescription - an order from your doctor for medicine, DME, therapy or other nursing services.

Prescription drugs - any prescription medication as defined in A.R.S § 32-1901 is prescribed by a health care professional to a subscriber to treat the subscriber's condition.

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

Primary care provider (PCP) - an individual who meets the requirements of A.R.S. §36-2901, and who is responsible for the management of the member's health care. A PCP may be a physician defined as a person licensed as an allopathic or osteopathic physician according to A.R.S. Title 32, Chapter 13 or Chapter 17, or a practitioner defined as a physician assistant licensed under A.R.S. Title 32, Chapter 25, or a certified nurse practitioner licensed under A.R.S. Title 32, Chapter 15. The PCP must be an individual, not a group or association of persons, such as a clinic.

Primary care physician - a physician defined as a person licensed as an allopathic or osteopathic physician according to A.R.S. Title 32, Chapter 13 or Chapter 17 and who otherwise meets the definition of Primary Care Provider (PCP).

Provider - any person or entity that contracts with AHCCCS or a Contractor for the provision of covered services to members according to the provisions A.R.S. §36-2901 or any subcontractor of a provider delivering services pursuant to A.R.S. §36-2901.

Provider fraud & abuse
• Falsifying claims/encounters that include the following items:
  – Alteration of a claim
  – Incorrect coding
  – Double billing
  – False data submitted
• Administrative/Financial actions that include the following items:
  • Kickbacks
  – Falsifying credentials
  – Fraudulent enrollment practices
  – Fraudulent third party liability (TPL) reporting
  – Fraudulent recoupment practices
• Falsifying services that include the following items:
  – Billing for services/supplies not provided
  – Misrepresentation of services/supplies
  – Substitution of services

 Qualified Medicare Beneficiaries (QMB) - members who qualify for both AHCCCS and Medicare who have their Medicare Part A and Part B premiums, coinsurance and deductibles paid for by AHCCCS.

 Rehabilitation services and devices - physical, occupational, and speech therapies, and items to assist in improving or restoring a person's functional level (A.A.C. R9-22-101).

 Referral - when your PCP sends you to a specialist for a specific, usually complex, problem.

 Room and board - a cost you pay for food and housing when you live in an alternative residential setting.

 Share of cost - the amount that AHCCCS determines a member must pay toward the cost of their care. Room and board is the amount that Mercy Care determines a member must pay toward the cost of assisted living.

 Skilled nursing care - a type of residential care that provide around-the-clock nursing care for persons who require a certain level of medical care and/or assistance.[1] Twenty-four hour nursing care is available to ensure that all medical needs and personal/daily needs are being addressed.

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

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

 Special health care needs - members who have serious and chronic physical, developmental or behavioral conditions and who require medically necessary health and related services of a type or amount greater than those generally required by members. All ALTCS members are considered to have special needs.

 Urgent care - urgent care is a category of walk-in clinic focused on the delivery of ambulatory care in a dedicated medical facility outside of a traditional emergency room. Urgent care centers primarily treat injuries or illnesses requiring immediate care, but not serious enough to require an ER visit.

 Definitions for maternity care services

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

 2. High-risk pregnancy refers to a pregnancy in which the mother, fetus, or newborn is, or is anticipated to be, at increased risk for morbidity or mortality before or after delivery. High risk is determined through the use of the Medical Insurance Company of Arizona (MICA) or American College of Obstetricians and Gynecologists (ACOG) standardized medical risk assessment tools.
3. **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).

4. **Maternity care** includes identification of pregnancy, prenatal care, labor/delivery services, and postpartum care.

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

6. **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.

7. **Postpartum care** is the health care provided for a period of up to 60 days post-delivery. Family planning services are included if provided by a physician or practitioner.

8. **Preconception counseling** services, as part of a well-woman visit, are provided when medically necessary. This counseling focuses on the early detection and management of risk factors before pregnancy, and includes efforts to influence behaviors that can affect a fetus (even before conception is confirmed), as well as regular health care. The purpose of preconception counseling is to ensure that a woman is healthy prior to pregnancy. Preconception counseling does not include genetic testing.

9. **Prenatal care** is the health care provided during pregnancy and is composed of three major components:
   a. Early and continuous risk assessment
   b. Health education and promotion, and
   c. Medical monitoring, intervention, and follow-up.