Molina Complete Care

Member Handbook

Covered services are funded under contract with AHCCCS.

MCCofAZ.com

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Effective for contract year 2023
(October 1, 2022–September 30, 2023)

MOLINA® HEALTHCARE

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Important phone numbers

Important phone numbers		
Member Services	(800) 424-5891 (TTY/TDD: 711)	We're here Monday-Friday 8 a.m. to 6 p.m. MST for questions about your benefits, help you find a doctor and help connect you to health care services and community resources.
24/7 Nurse Advice Line	(800) 424-5891 (TTY/TDD: 711)	Our Nurse Advice Line is available 24/7, every day of the year. The Nurse Advice Line is staffed with nurses who can help you get the information and services that you need. Our Nurse Advice Line nurses can help you with things like: • Deciding when to visit your doctor, or go to an urgent care or emergency room (ER) • Understanding your medications and how to take them safely. Answering health questions about your child's fever, help with managing a health condition like diabetes or have any other health concern • Learning about checkups or preventive care
Statewide Behavioral Health Crisis Hotline	(844) 534-4673 (HOPE)	These are here if you or someone you know is experiencing a behavioral health crisis. You can call the Behavioral Health Crisis Line 24/7, every day of the year. If you have thoughts about harming yourself or someone else, you should get help right away by calling 911.

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Important phone numbers		
Non-emergency transportation	833-474-5060 (TTY/TDD: 711)	We can help you get rides to your covered medical appointments. [Veyo] Transportation regular scheduling hours: 8 a.m. - 6 p.m. Monday through Friday. • 72 hours/3 business days advance notice is required • Reservations can be made for trips occurring in the current or following month • Member is required to provide all necessary child-safety/booster seats When you call to schedule transportation, please have the following information ready: • Your first and last name • Your Medicaid ID number • The mode of transportation you require (standard/ambulatory, wheelchair, stretcher, etc.) • Your home address where we will pick you up • Your telephone number to contact you regarding your appointment • Your appointment time • The address of your medical provider where we will drop you off • The type of medical provider you are seeing (physician, laboratory, etc.) • If this will be a recurring appointment • If additional passengers will travel with you (one additional passenger is allowed)

Important phone numbers		
		"Will Call" for return trips (when members are not sure how long appointment will last): • Member should contact the [Veyo] call center at 833-474-5060. • Provider has up to 60 minutes from the time of the call to pick up Member.
Pharmacy	(800) 424-5891 (TTY/TDD: 711)	Call us if you need help getting your medicine.
Care management	(800) 424-5891 (TTY/TDD: 711)	Our care management team works with you to coordinate your health care and connect you with local resources when needed.
Utilization management	(800) 424-5891 (TTY/TDD: 711)	Our utilization management team looks at standards to decide if certain requested treatments and services are medically needed. Decisions are based on what is right for each member and on the type of care and services that are needed. We look at standards of care based on: • Medical policies • National clinical guidelines • Medicaid guidelines • Your health benefits

Nurse Advice Line

Our Nurse Advice Line is available 24/7, every day of the year. The Nurse Advice Line is staffed with nurses who can help you get the information and services that you need.

Phone Number: (800) 424-5891 (TTY/TDD: 711)

Care management

We put you at the center of what we do. We offer community-focused support for our members. This is part of our Integrated Health Neighborhood℠ model. Our team works with you to coordinate your health care, including physical and mental health needs and connect you with local resources.

If you qualify, we'll give you a care manager. They can help you create a personal service plan. This will be based on your health goals and desires.

Your care manager can:

- Work with you to create your personal service plan
- Answer questions about your health care needs
- Help you decide if you should go to your PCP or go to an urgent care center or emergency room
- Help you find services and resources in your area
- Set up a no-cost ride to your doctor visit

If you have questions about the care management program, call us at (800) 424-5891 (TTY/TDD: 711).

How to get emergency, urgent and after-hours care

What is an emergency?

An emergency is when you have an illness or injury that could cause serious injury or death if it is not treated right away.

What do you do in an emergency?

Call 911 or go to the closest emergency room right away. You don't have to call MCC first. Prior authorization is not needed for emergency services. You can go to any hospital for emergency care, even if you are in another city or state.

Let the hospital know you're a member of MCC. Show them your member ID card.

What is urgent care?

You should use urgent care for a non-life threatening, sudden illness, injury or condition that isn't an emergency, but needs attention right away.

Some examples of urgent care are skin rashes, infection, flu, sprains and minor cuts.

Where do you go when you need urgent care?

If it's during the workday, call your primary care provider (PCP). If you're not able to see your PCP, or if it's after hours, you can go to one of the urgent care centers we work with.

To find a list of urgent care centers, visit www.MCCofAZ.com or call Member Services at (800) 424-5891 (TTY/TDD: 711).

Behavioral health crisis

You can call the 24/7 Behavioral Health Crisis Line for your county at any time to get help with a behavioral health crisis.

The crisis line is confidential and open to anyone who needs help, not just Medicaid members. Trained crisis intervention specialists are available to help you over the phone.

Some signs of a behavioral health crisis are:

- Thinking about or being afraid you might hurt yourself
- Thinking about or being afraid you might hurt someone else
- Hopelessness
- Not wanting to do things you like
- Not wanting to be with your friends or family
- Mood swings, anxiety or getting angry easily

For a life-threatening emergency, call 911.

Behavioral Health Statewide Crisis Hotline:

- (844) 534-4673 (HOPE)

For young people:

- **Teen Lifeline:** (602) 248-TEEN (8336) (call or text)

For Veterans:

- **Veterans Crisis Line:** (800) 273-8255 (press 1)
- **Be Connected:** (866) 4AZ-VETS (429-8387)

Additional Arizona Crisis Lines:

- **Gila River and Ak-Chin Indian Communities:** (800) 259-3449
- **Salt River Pima Maricopa Indian Community:** (855) 331-6432
- **Tohono O'Odham Nation Crisis Line:** (844) 423-8759

The National Suicide Prevention Lifeline
The National Suicide Prevention Lifeline is a national network of local crisis centers providing emotional support to people in suicidal crisis or emotional distress 24 hours a day, 7 days a week. Call to talk to someone who can help. If you have thoughts about harming yourself or someone else, you should get help right away by calling 911.

Call:

- **The National Suicide Prevention Lifeline: dial 988 or** (800) 273-TALK (8255)
- **The National Substance Use and Disorder Issues Referral and Treatment Hotline:** (800) 662-HELP (4357)

Text:

- Text the word "HOME" to 741741

These crisis lines provide immediate and confidential help. Types of crisis services available include:

24/7 Crisis Line - Trained crisis intervention specialists are available, every day of the year, to help over the phone. The Crisis Line is confidential and is open to anyone who needs help.

23-hour crisis observation and stabilization units - Crisis stabilization units provide supportive outpatient therapy for up to 23 hours. Members will stay on the unit until the crisis has resolved. 23-hour crisis observation and stabilization units are voluntary.

Solari Crisis and Human Services Warm Line (24 hours a day) - This line is a no-cost and private phone service. The staff taking your calls are peers who have dealt with behavioral health issues. They can support you if you need someone to talk to. Please call <(602) 347-1100> to talk to someone right away.

Tribal Warm Line – (855) 728-8630 You can call Monday-Friday 8 a.m. to 5 p.m.

Mobile teams - The crisis line provider works to get you help where you are. As needed, crisis specialists can send a mobile team of trained crisis intervention specialists to you or your loved one to conduct a face-to-face assessment and intervention. A mobile team can meet you in the community and get you somewhere that's safe.

Emergency room-based assessments- Crisis lines can arrange for assessments during emergency room visits. This service can help identify clinically appropriate services for individuals experiencing a serious behavioral health crisis.

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Substance use disorder services

Arizona Opioid Assistance & Referral (OAR) Line

The Arizona OAR Line is a 24/7 hotline that helps anybody with pain and opioid use disorders. This hotline is answered by medical experts at the Poison and Drug Information Centers in Arizona. For help, call (888) 688-4222.

You may use substance use treatment services in our provider network. They can help treat substance use disorders. You can find a provider:

- Online at www.MCCofAZ.com > Find a Doctor or Pharmacy.

OR

- Calling Member Services at (800) 424-5891 (TTY/TDD: 711). You can call Monday-Friday 8 a.m. to 6 p.m. MST.

MCC also has behavioral health professionals who can help you find a provider in your area.

AHCCCS Opioid Service Locator: https://opioidservicelocator.azahcccs.gov/

Getting culturally competent materials and services

If you need help understanding information

We provide no-cost help and services, such as auxiliary aids, to people with disabilities. We want you to be able to talk with us easily.

We offer these at no cost:

- Qualified sign language interpreters
- Written information in many formats such as:
  - Large print
  - Audio
  - Accessible electronic formats
  - Other formats

Contact us at (800) 424-5891 (TTY/TDD: 711) if you need any of these services.

If you don't speak English

We provide language services at no cost to people whose first language is not English. We offer:

- Qualified interpreters
- Information written in other languages

We state which providers speak other languages in our provider directory. To find a provider who speaks another language, visit www.MCCofAZ.com and choose "Find a Doctor or Pharmacy." The MCC provider directories will state if an office has interpreter services. If you have any other cultural needs or need help finding a provider that speaks a language other than English, please call Member Services at (800) 424-5891 (TTY/TDD: 711). You can call Monday-Friday 8 a.m. to 6 p.m. MST.

Accommodating physical disabilities

If you need help finding a provider or seeing if a network provider can meet your needs, please call Member Services at (800) 424-5891 (TTY/TDD: 711). You can also find information in our provider directory at www.MCCofAZ.com using our Find a Doctor or Pharmacy tool.

How to find a doctor or provider

We work with different doctors and providers. As an MCC member, you can choose the providers you see from the list of providers we work with. This is called "in-network."

Our list of the providers is called the provider directory. This lists all of the providers, hospitals, urgent care centers and pharmacies that work with MCC.

You'll need to see providers who work with MCC. If you don't, your visit may not be covered. If you have any questions, call Member Services at (800) 424-5891 (TTY/TDD: 711).

How to get care from out-of-network providers

Molina Complete Care is a managed care plan. You should use the providers in our network. To see if a provider is in our network, you can call Member Services at (800) 424-5891 (TTY/TDD: 711) You can call Monday-Friday 8 a.m. to 6 p.m. MST.

We do not pay for out-of-network care, except for:

- Emergency care
- Family planning services
- When you are coming from another health plan
- When there are no providers close to you

If you cannot get the care you need from a specialist in our network, you can see a specialist outside of our network. You can ask your PCP to submit an authorization to see an out-of-network provider.

An out-of-network provider can also ask for a prior authorization to treat you. If this request is approved, you can see the out-of-network provider.

If you go to a non-contracted provider, please call Member Services at (800) 424-5891 (TTY/TDD: 711). We can help you find an in-network provider.

Getting help using our provider network

We can help you get the care you need and use our provider network. If you have certain illnesses or use services regularly, a care manager may call you. He or she will help meet your needs. They can help you find a provider in our network, if needed. You can also get help by calling Member Services at (800) 424-5891 (TTY/TDD: 711). We'll have a care manager call you back right away or regularly.

How to get a provider directory

To get a provider directory at no cost:

- Go to our website at www.MCCofAZ.com
- Call us at (800) 424-5891 (TTY/TDD: 711) and ask us to mail you a printed copy at no cost

About MCC and managed care

Areas we serve in Arizona

We are proud to offer Medicaid and KidsCare benefits to members in the Central region. This includes the Gila, Pinal and Maricopa counties. We do not serve members in ZIP codes 85542, 85192, 85550. These are included in the South region.

Molina Complete Care (MCC)

MCC is a health plan, or managed care organization (MCO). We offer both behavioral health and physical health services.

We help members who are eligible for Medicaid and KidsCare benefits get the behavioral health and physical health services they need.

If you're eligible for Medicaid or KidsCare, you'll have a health plan – that's us! We will:

- Work with your doctors and providers to pay for your medical services
- Help you get rides to your appointments
- Help you get the prescriptions and medical equipment you need and more

You should see your primary care provider (PCP) for your annual visit and when you're feeling sick (unless it's an emergency and you need care right away). This will help your PCP get to know you and your health care needs.

Your PCP is your personal doctor who will manage all of your health care. Your PCP is the:

- "Gatekeeper" for your health. This means that your PCP will set up most of your health care.
- Main doctor who will give you the health care services you need.

It's important to see your PCP at least once a year, especially when you're feeling sick. Your PCP knows your health care needs. If you need specialty care, they can refer you to a specialist. Your PCP may treat behavioral health conditions too. If you have a behavioral health condition, your PCP may refer you to a behavioral health specialist.

A few things to keep in mind:

- It's important to let your PCP know if there have been any changes to your health. This way they can give you the care you need.
- Your PCP should know about any other providers you are seeing and if they have given you any medicine(s).
- Your PCP plays an important role in making sure all of your health care is coordinated between all of your providers.
- Visiting your PCP helps you build a relationship so they know you and your health history.

Your PCP can also help with:

- Substance use disorders
- Anxiety
- Depression
- Attention Deficit Hyperactivity Disorder (ADHD)

To get these services, make an appointment with your PCP or call Member Services at (800) 424-5891 (TTY/TDD: 711).

You can also give us a call if you would like to change your PCP.

Your member ID card

If you have an Arizona driver's license or state-issued ID, AHCCCS will use your photo from the Arizona Department of Transportation Motor Vehicle Division to verify.

When you go to a provider, your photo will show up next to your coverage information. This helps protect you and stop anyone else from using your ID card.

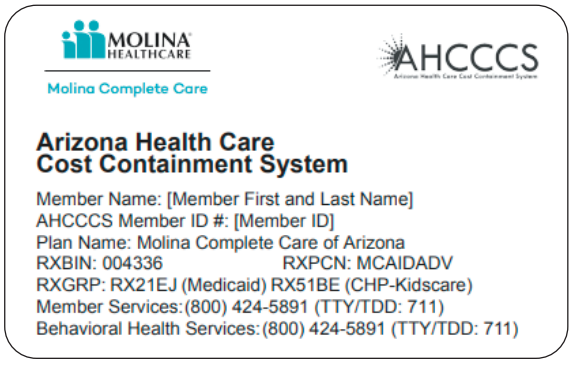
You must protect your member ID card. Any misuse of your card can lead to losing your benefits or legal action. Misuse of your card may include:

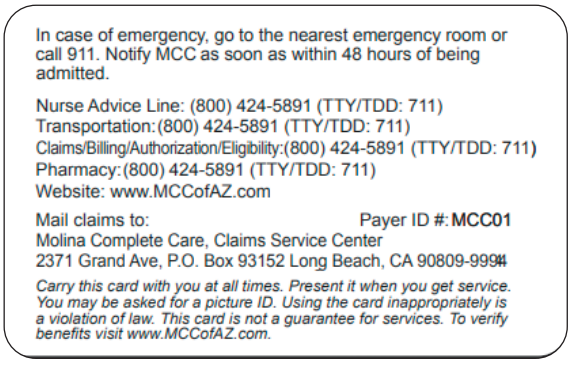
- Loaning it to someone
- Selling it
- Giving it to someone

It's important to keep your card at all times. Do not throw it away!

When you become an MCC member, we'll send you your member ID card in the mail. Make sure you keep this safe. Bring your member ID card with you when you:

- Get behavioral health services
- Get physical health services
- Fill a prescription at the pharmacy





If you move or change your personal information

It's important to keep your personal information up to date so we can reach you.

If you need to report a change in your household, your name, your mailing address, the size of your family or your phone number, contact the place where you applied for AHCCCS:

- DES www.healthearizonaplus.gov or (855) HEA-PLUS (855) 432-7587
- KidsCare www.healthearizonaplus.gov or (855) HEA-PLUS (855) 432-7587

If you move outside our Geographical Service Area (GSA) but stay in Arizona, you'll need to choose a new plan. If this happens, you'll get a letter from AHCCCS asking you to choose a new plan.

If you move out of the state or out of the country, you are no longer eligible for services from AHCCCS. You can check with your new state or country to see what they offer.

You can call Member Services at (800) 424-5891 (TTY/TDD: 711) if you have any questions about your health plan.

Choosing or changing your health plan

As a Medicaid or KidsCare member, you can choose your health plan. There are certain times when you can choose a health plan. The first time is when youfill out the application for AHCCCS benefits. The second time is one year later during the Annual Enrollment Choice (AEC).

Enrollment application

If you don't choose a health plan when you sign up for your benefits, AHCCCS will assign one for you. You have 90 days to make a change to your health plan.

The plan AHCCCS assigns you to depends on a couple of things:

- If you have a family member that already has an AHCCCS health plan
- If you got your eligibility back within 90 days of losing your eligibility

Annual Enrollment Choice (AEC)

Every year, you have a chance to change plans during a certain time. This is called Annual Enrollment Choice (AEC). If you enrolled with AHCCCS in March, your AEC date will be March every year.

AHCCCS will send you a letter two months before your AEC date. To make a change, contact AHCCCS to complete the enrollment process before the AEC date. If you do not notify AHCCCS before the last day of your AEC month, you will stay with your current health plan.

If you are having any problems getting your health care, please call us so we can help you.

Changing health plans

You can change your health plan outside of your AEC date if you:

- Want to switch to the health plan your family member has
- Did not get to choose a health plan
- Did not get a letter about the AEC from AHCCCS
- Were not able to take part in the AEC

You can also change health plans for continuity of care. This means that you can see the same doctor for a specific medical condition.

We may only consider a request to change health plans for one of these:

- You are pregnant and were already getting prenatal care when you were enrolled in the health plan

- You need to continue treatment with a provider you were seeing when enrolled in a different health plan. This is not an automatic process. Your provider must prove to the health plan that you want to leave and the health plan you want to join is necessary.

If you need help, please call Member Services at (800) 424-5891 (TTY/TDD: 711).

Letting others help you make health care decisions

There may be times when you want to let someone see your health information. This could be a family member or close friend. Feedback from family or a designated health care decision maker is important. It gives you support to meet your health care goals. During provider visits, let them know who you want to involve in your treatment planning. Bring them with you to your appointments if you can.

Because of privacy laws, your providers need your okay before:

- Anyone else can be involved with your treatment planning
- See your health information
- Make decisions for you

If you want someone to be involved in your treatment planning and/or see your medical information, you'll need to fill out a Consent to Release Protected Health Information (PHI) form. You can get one of these from your provider. On this form, you can tell your providers what type of information you want shared and who you want to be involved.

Getting health care after you change health plans

We want to help you have an easy move when you change health plans. This includes when you change health plans for one of these:

- Moving from the Fee-for-Service (FFS) program to MCC
- Moving from another health plan to MCC
- Moving from MCC to another health plan
- Moving from MCC to the FFS program

If your provider is not within our plan, you can keep seeing them for a certain amount of time. After this time, we'll:

- Work to add your provider into our network

  -OR-
- Help you move your services to providers in our network

Our team will work with you to make sure this move is easy. We'll be here to answer any questions and help you get set up with your new provider, if needed.

The time frame depends on the type of care and if you're currently getting care from that provider. If you have a special situation, we'll work with you to fix this case-by-case. See the chart for more details:

Type of service	Transition time frame
Behavioral health	You can see your current provider for six months or until you finish your current treatment, whichever comes first
CRS services	You can see your current provider for six months or until you finish your current treatment, whichever comes first
MSIC services	You can continue to go to the same MSIC for six months or until you finish your current treatment, whichever comes first

Type of service	Transition time frame
Care from a specialist	You can see your current provider for six months or until you finish your current treatment, whichever comes first
Care from a PCP	You can see your current PCP for 90 days or until you finish your current treatment, whichever comes first
Care from an OB/GYN	If you're in your third trimester (or you are expected to deliver within 30 days) you can stay with your current OB/GYN

A coordinator will work with you to make sure this move is easy:

- We'll make sure your scheduled appointments are not delayed because of this move.
- We'll work closely with our pharmacy staff during your move to make sure your medicines are filled.
- Our coordinator will update your providers, so they know you are now an MCC member.
- We'll be here to answer any questions and help you get the care you need.

If you switch to a different health plan, a coordinator will:

- Ensure continuity of care
- Continue access to services
- Make sure all of your needs are met with your new health plan

Our coordinator will make sure your new health plan knows about:

- Past and upcoming appointments
- Current medicines
- Durable medical equipment
- Scheduled rides
- Any other specialty care needs

If you are in an inpatient setting at the time of the change, we will let your new health plan and the facility you are at now know so they can set up your care. Our coordinator will work with your new health plan to make sure you have a smooth

transition. We'll share any medical records with your new health plan so you get the care you need.

We want to help you have an easy move whether you start as a new member with us or switch to another health plan.

How to get emergency and urgent care

What is an emergency?

An emergency is when you have an illness or injury that could cause serious injury or death if it is not treated right away.

What to do in an emergency

Call 911 or go to closest emergency room right away. You don't have to call MCC first. Prior authorization is not needed for emergency services. You can go to any hospital for emergency, even if you are in another city or state.

Let the hospital know you're a member of MCC. Show them your member ID card.

Emergency transportation

If you are having a medical emergency and need a ride, call 911. We will pay for emergency transportation. This is called an ambulance ride.

(chart on next page)

Types of care and where to get it

This table below gives a quick overview of what type of care is best for you and where to get it:

Type of care	What care you can get
Emergency room (ER)	Go to the **ER** when you have a serious problem that needs care right away. Emergencies include problems like: • Heart attack or stroke symptoms • Severe bleeding • Severe trouble breathing • Severe pain
Primary care provider (PCP)	Your **PCP** knows you and your health history. Go to your PCP for your annual checkups and if you're not feeling well, but it's not an emergency.

Type of care	What care you can get
Urgent care clinics	**Urgent care clinics** are used for sprains, burns and broken bones. They can also do: • X-rays • Throat cultures • Routine health care • Sports physicals • Shots Urgent care clinics are open after hours and on the weekends. You can walk in or call to make an appointment.

Get a ride to your medical visits

Need a ride to your medical visits? Please try to get a family member, friend or neighbor to help you get to your visits. If you can't find a ride, we'll help you. Call us at (800) 424-5891 (TTY/TDD: 711) to set up a ride. Please call at least 72 hours before your visit.

Covered benefits and services

With your AHCCCS benefits, you can use medically necessary services. Use the list below to see what services you get. You can also learn more at www.azahcccs.gov > *Members/Applicants > Covered Services*.

If you have questions about your benefits, please call Member Services at (800) 424-5891 (TTY/TDD: 711).

Some members have AHCCCS and Medicare. These members are called "dual eligible." If you have Medicare, MCC may help pay for extra things. This may be your Medicare coinsurance and deductibles.

If you have Medicare and Medicaid, you'll want to see a PCP who works with both. If you need help finding a PCP, call Member Services at (800) 424-5891 (TTY/TDD: 711).

Covered service for all members can be:

- Behavioral health *(see Covered behavioral health services for all members section)*
- Breast reconstruction after mastectomy
- Chemotherapy and radiation
- Circumcisions, when medically necessary (prior authorization required)
- Diabetes testing and supplies
- Cardiac (heart) and pulmonary (breathing) rehab
- Dialysis
- Durable medical equipment (DME) and supplies
- Emergency care (includes care to stabilize you after an emergency)
- Emergency dental care:
  - Limited to $1000 per year
- Emergency and non-emergency transportation
- End of life care
- Family planning services:
  - Birth control
  - Contraceptives
  - Family planning counseling
- Hearing loss test
- High tech radiology, includes:
  - Magnetic resonance imaging (MRI)
  - Magnetic resonance angiogram (MRA)
  - Positron emission tomography tests
  - (PET Scan)
- HIV/AIDS therapy and counseling services
- Home health care
- Hospice services:
  - Inpatient
  - Outpatient
- Immunizations (shots)
- Incontinence briefs (for members over 21, when needed)
- Inpatient hospital stays may include:
  - Physical therapy
  - Occupational therapy
  - Speech therapy
- Lab, X-rays, medical imaging
- Maternity care
- Medical equipment and supplies
- Medical foods
- Nursing facility stay:
  - Limited to 90 calendar days per year
- Nutritional tests and medical foods
- Occupational therapy
  - 15 visits per calendar year
- Orthotics and prosthetics
- Out-of-network services
- Outpatient services
- Pain management services
- Physical therapy
  - 15 visits per calendar year
- Podiatry (foot and ankle)
- Pregnancy care
- Prescription medicines and injections

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- Primary care provider (PCP) office visits:
  - Wellness exams
  - Preventive care
- Preventive screenings and tests:
  - Pap tests
  - Mammogram
  - Colonoscopy
- Rehab therapy
- Respirational therapy
- Specialist office visits
- Second opinions
- Surgery
- Smoking cessation
- Transplants that are approved by AHCCCS (organ and tissue)
- Urgent care

Well-visits are covered for all members. As part of your wellness visit, you get:

- Well woman exams
- Breast exams and prostate exams for members 21 years and older
- Medical history
- Physical exam
- Health screening
- Health counseling
- Any medically necessary shots

Additional services covered for members under age 21

On top of covered services, members under age 21 also get

- Chiropractic care (when medically necessary)
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) includes:
  - Wellness exams
  - Hearing exams and hearing aids
  - Preventive dental care
  - Orthotics covered for AHCCCS members under the age of 21
- Dental screenings and treatments
- Glasses
- Outpatient physical, occupational and speech therapy
- Personal care services that are necessary to meet a medical need. This includes help with:
  - Activities of daily care
  - Bathing
  - Toileting
  - Walking
- Vision exams

Some services have specific limits:

Type of service	Any specific limitations
Behavioral health services	See section below on covered behavioral health services
Alternative home- and community-based services (HCBS)	Members should use HCBS instead of a nursing home when medically able
Nursing home	Up to 90 days per contract year (contract year is from Oct. 1 to Sept. 30)
Personal care items	Only covered when used to treat a medical condition
Vision care	• Limited to medical eye conditions • Eye exams and glasses covered for children under 21 • Eyeglasses covered for adults after undergoing cataract surgery

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Type of service	Any specific limitations
Orthotic devices	MCC only covers orthotic devices when all three below are met: • The orthotic is medically necessary • The orthotic costs less than all other treatments and surgery to treat the same conditions • The orthotic is ordered by a doctor or primary care provider (nurse practitioner or physician assistant)

Covered behavioral health services for all members

- Behavioral health counseling and therapy:
  - Individual
  - Group and family
- Screening, evaluation, assessment and testing
- Substance use services:
  - Intensive outpatient
  - Residential
  - Inpatient
- Multisystemic therapy (for members under 21 years old)
- Auricular acupuncture (a type of acupuncture that involves inserting needles into specific points on the ear) *
- Skills, trainings and development and psychosocial rehabilitation living skills training (including supported employment services)
- Behavioral health prevention/ promotion education and medication training
- Help and training to stay employed
- Laboratory, radiology and medical imaging
- Medical management
- Electroconvulsive therapy
- Care management
- Personal care services
- Home care training and family support
- Self-help and peer services
- Home care training for home care client
- Unskilled respite care
- Wraparound services to keep supportive housing
- Behavioral health respite care:
- Limited to 600 hours per year, October 1, 2021 - September 30, 2022
- Sign language or oral interpretative services provided at no cost to the member.

- Emergency and non-emergency transportation
- Crisis intervention:
- Mobile, community-based
- Stabilization, facility-based
- Over the phone via crisis line
- Hospital
- Subacute facility
- Residential treatment center
- Behavioral health residential facility (without room and board*)
- Supervised behavioral health treatment and day programs
- Therapeutic behavioral health services and day programs
- Community psychiatric supportive treatment and adult behavioral health therapeutic homes
- *Services not available with Title XIX/ XXI funding but may be provided if other funds available.

Services not covered

There are some services MCC does not pay for. This includes:

- Pregnancy termination (unless the doctor tells us that the mother's life is in danger or the pregnancy is due to a rape, incest, or if termination is medically necessary)
- Counseling services for pregnancy termination
- Cosmetic surgery (this includes breast enlargement or reduction)
- Procedures or treatments that are considered experimental or for research purposes
- Infertility services (to help someone have children)
- Reversal of any permanent birth control method
- Services that need prior authorization that were not authorized, including certain medicines:
  - You have the right to appeal any decision on prior authorizations, but you must go through the appeal process. See the Appeal section for more information.
- Sex change operations
- TMJ disorders except when due to a recent trauma
- Treatment to straighten teeth (braces for your teeth)
- Immunotherapy for adults
- Penile implants and vacuum devices

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- Services that are not medically necessary
- Services that you agreed to pay for yourself
- Services from a provider that is not in our network, unless approved by MCC or during the transition of care period

How to access non-title XIX/XXI services

Members who qualify for Medicaid (Title XIX/XXI) may get some of these services:

- Room and board
- Mental health services (formerly known as traditional healing)
- Auricular acupuncture
- Childcare
- Supportive housing rent/utility subsidies
- Relocation services

Members will have to meet the criteria to get these services. Non-Title XIX/XXI services are paid for by the Regional Behavioral Health Authority (RBHA). Members who qualify for services should talk with their behavioral health provider (if already getting services) or call Member Services at (800) 424-5891 (TTY/TDD: 711) and ask to speak with a care manager.

Here is a list of RBHA facilities by central region county:

Mercy Maricopa Integrated Care (Maricopa County): (800) 564-5465
Health Choice Arizona (Gila County): (855) 354-9006
Arizona Complete Health Complete Care (Pinal County): (866) 495-6735

Housing services

Rent assistance and support

If you need help finding a place to live or help paying for housing, MCC can help connect you to community and housing resources in your area.

If needed, MCC will refer you to the Regional Behavioral Health Authority (RBHA) for Non-Title XIX/XXI services and local community housing providers. Please call Member Services at (800) 424-5891 (TTY/TDD: 711) Monday-Friday 8 a.m. to 6 p.m. MST for help. We have a care management team who can help you get set up with these services.

Getting help from housing specialists

Our housing specialists can help if you are homeless or at risk of losing your home. We can:

- Give you resources within your area
- Make any referrals, if needed
- Help you find options that accept rental subsidy or vouchers, if needed
- Help you find short term shelters, if needed

We work with local agencies to find funding and ways to help with homelessness. We also train our staff and community agencies on housing needs, resources and their impact.

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For more information, please contact:
Cinda Thorne
Housing Administrator (480) 440-6807
Cinda.Thorne@molinahealthcare.com

Housing services contact information

YOUTH ONLY (AGES 18–24)
Native American Connections
Offers services for youth ages 18-24 & single Native adults
Home Base: (602) 263-5531
NAC's Team: (602) 648-9739
housing@nativeconnections.org

FAMILIES ONLY (With Dependent Children) Family Housing Hub
3307 E Van Buren St Phoenix AZ 85034
(602) 595-8700
Hours of Operation: Contact the Hub for hours and additional family entry point locations
Family Housing Hub Flyer

U.S. MILITARY VETERANS ONLY
VA – Community Resource & Referral Center (CRRC)
1500 E Thomas Ave, Suite 106 Phoenix AZ 85014
(602) 248-6040

Hours of Operation:
Monday–Friday 7:30 a.m.–4:30 p.m.
UMOM's Youth Outreach
(480) 868-7527

SINGLE ADULTS ONLY
(NO Dependent Children)
Brian Garcia Welcome Center
206 S 12th Ave Phoenix AZ 85007
(602) 229-5155
Hours of Operation:
Monday–Friday 7:30 a.m.–11 p.m.

Community Bridges
Offers access to several specialized programs to meet individual's needs
Locations across Maricopa County

Access to care contact: (877) 931-9142
CBI PATH Outreach Team
Street outreach services to individuals displaying signs and symptoms of mental illness 24-hour

Department of Housing and Urban Development (Local):
Phoenix Field Office
One North Central Avenue, Suite 600
Phoenix, AZ 85004
Phone: (602) 379-7100
Email: AZ_Webmanager@hud.gov
Fax: (602) 379-3985
TTY: (602) 379-7181 or Dial 7-1-1 (Not available in all areas.)
Jurisdiction: State of Arizona
https://www.hud.gov/states/arizona/offices

Housing Authority of Maricopa County
Address: 8910 N 78th Ave, Peoria, AZ 85345
Hours: Open 8 a.m. – 5 p.m.
Phone: (602) 744-4500

Gila County Housing Authority:
5515 S Apache Ave
Globe, Gila County, Arizona 85501
(928) 425-7631

Pinal County Housing Authority:
Address: 970 11 Mile Corner, Casa Grande, AZ
85194 Hours: Open 8 a.m. – 5 p.m.
Phone: (520) 866-7201

Gila County Housing Choice Voucher Program:
Patricia Campos, Program Manager
5515 S Apache, Suite 200
Globe AZ 85501
(928) 425-7631

HOM, Inc.
Address: 5326 E Washington St #5, Phoenix, AZ 85034
Hours: Open 8 a.m. – 12 p.m. and 1 p.m. – 5 p.m.
Phone: (602) 265-4640

Veterans services

Did you know Molina Complete Care of Arizona has a Military and Veteran Advocate ready to help military veterans and their families get the care they need?

We know and value the sacrifices that veterans of the U.S. Armed Forces, those who have served, and their families have made. That's why we're stepping up to help you.

Too often, veterans return home from service with physical or mental health challenges. Working with the healthcare system is one battle you shouldn't have to fight. MCC's Military and Veteran Advocate can:

- Explain your AHCCCS benefits and how to use them
- Show you how to work with the Veterans Administration (VA), the Be Connected program, and other resources

Call Member Services at (800) 424-5891 (TTY/TDD: 711) and ask to be connected to our Military and Veteran Advocate.

Office of Individual and Family Affairs (OIFA)

The Office of Individual and Family Affairs, called OIFA (oy-fuh), is a team of people here at Molina that will join you on your healthcare journey when you want or need it.

- We have been where you are. We share stories of our own health experiences and recovery.
- We speak your language.
- We will listen without boxes to check or time constraints.
- We will help you navigate the healthcare system.

- We will visit you in the hospital or in the community if you want.
- We will connect you to community resources.
- We will elevate your voice.
- We will support you as you voice your concerns and complaints.
- We will connect you with others like you who want to change how our system works.
- We believe recovery and wellness are possible for every person.

At AHCCCS, OIFA promotes recovery, resiliency, and wellness. We have the same kind of team here. In fact, every AHCCCS health plan has one!

We are experts in mental health and substance use, and can get involved with other health situations. We emphasize the power of lived experience, peer and family relationships, and member voice and choice.

For more information:
Call our OIFA Administrator: (480) 263-1001
Email: mccaz-oifa@molinahealth.com
Check out AHCCCS OIFA and their awesome Navigational Tools:
https://www.azahcccs.gov/AHCCCS/Downloads/OIFAatAHCCCS.pdf

End of life care

End of life care is the care you get to help you feel comfortable when your health is declining or you have a chronic, complex or terminal illness. A trained team of caregivers will work with you and your family to help you decide what treatment you want and give you information about your illness. The goal of end-of-life care services is to give you treatment, comfort and quality of life through the rest of your life. Services include:

- Physical and/or behavioral health treatment
- Referrals to community-based agencies
- Support services provided by family, friends and/or volunteers

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End of life care also allows you to get information about advance care planning, palliative care and hospice services. Your doctor will work with you and/or your family on available services.

The Arizona Attorney General's office offers a complete life care planning packet and forms at no cost to you. To request a packet, go to www.azag.gov/seniors/life-care-planning or call (602) 542-2123 or (800) 352-8431 to have them mailed to you.

Advance directives and living wills

One of your rights as a member is to help make decisions about your health care and treatment. To make sure your doctors know your wishes, you should write them down. This is called an advance directive.

This lets your family and doctors know what you want to do in case you get sick and cannot say what you want.

There are different types of advance directives. Some examples are health care power of attorney and living will.

The Arizona Secretary of State's office has several no-cost resources to help you with your advanced directive. The Arizona Advance Directive Registry is a no-cost registry to electronically store and access your medical directives. The secure and confidential program gives peace of mind to registrants and their families. It is easy to access for all health care providers. You can learn more at www.azsos.gov/services/advance-directives.

Health care power of attorney

This is a person who you give permission to make your health care decisions if you are not able to. This may be a spouse, relative or close friend. This is called an "agent."

Living will

This is a document where you write out what type of health care treatment(s) you do or do not want. This is used if you are not able to tell your providers what you want.

You can also tell your doctor whether or not to make special efforts to save your life if you are seriously ill. This might be if you are being put on a ventilator to help you breathe. You should give your doctor a copy of your power of attorney and living will and also keep a copy for yourself. You can make changes to these at any time.

Make sure your doctor and providers have the most recent copies if you make changes.

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How to get health care services

Seeing a specialist

Your primary care provider (PCP) is who you should see for most of your health care. Sometimes you might need specialty care. If you do, you'll need to talk to your PCP and get a referral to a specialist.

There are times when you don't need a referral for a specialist. This is known as "self-referral":

- Women can see an in-network OB/GYN for preventive and routine services
- All members can self-refer for services with an in-network behavioral health provider
- Members under 21 years old can self-refer for dental and vision screenings with in-network dentists and vision providers
- Members with special health needs may directly access health care services from a specialist as needed for their condition and needs

To use the "self-referral" process, call the providers directly to make an appointment. You don't have to go through your PCP first. If you need help finding a provider, please call Member Services or search our line provider directory at www.MCCofAZ.com. Services that are provided by out-of-network providers will need a prior authorization first.

We'll also get you care outside of our network when the type of provider needed and available in Molina Complete Care's network does not:

- Provide the service you need (including counseling or referring services) because of moral or religious objections

For information on how to access counseling or referral services, please call Member Services at (800) 424-5891 (TTY/TDD: 711) Monday-Friday 8 a.m. to 6 p.m. MST.

Health care services for American Indian members

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.

MCC's team includes a Tribal Liaison who can help assist you.

Call Member Services at (800) 424-5891 (TTY/TDD: 711) and ask to be connected to our Tribal Liaison.

Your primary care provider (PCP)

Your primary care provider is your doctor who will give you the health care services you need. This includes well visits and times when you're feeling sick. Going to your PCP for your health care helps you build a relationship so they know you and your health history.

We gave you a PCP when you joined MCC. If you want to change your PCP, call Member Services at (800) 424-5891 (TTY/TDD: 711) and we'll help you find one.

You have the right to choose any PCP that is part of MCC. You may choose an obstetrician/gynecologist (OB/GYN) as your PCP if the OB/GYN agrees to it.

Making an appointment

When you want to see your PCP or provider, call their office and ask to see the provider. You'll also want to say the reason you need the visit. This will help the person making the appointment know how soon you need to be seen.

Make sure you keep your appointment with your provider. Write it down on your calendar or make a note so you remember the date and time. If you need to change or cancel your appointment, call the doctor's office ahead of time and let them know. Try to call and cancel or change your appointment at least one day in advance.

Need help making an appointment? Need a ride to your visit?
Call Member Services at (800) 424-5891 (TTY/TDD: 711).

AHCCCS has rules in place so you can get the care you need, when you need it. One of the rules is that providers need to make sure you can get an appointment within a specific amount of time.

The following chart lets you know when you can get an appointment with your provider:

Type of provider	Type of care	Wait time
Primary care provider (PCP)	Urgent care	As soon as possible, but no more than two business days
	Routine care	Within 21 calendar days
Specialty provider (including specialty dentists)	Urgent care	As soon as possible, but no more than two business days
	Routine care	Within 45 calendar days
Dental provider	Urgent care	As soon as possible, but no more than three business days
	Routine care	Within 45 calendar days
Maternity care	Care in first trimester	Within 14 calendar days
	Care in second trimester	Within seven calendar days
	Care in third trimester	Within three business days

Type of provider	Type of care	Wait time
	Care for a high-risk pregnancy/high-risk emergency (if you're having an emergency, contact your provider immediately or go to the emergency room)	As soon as possible, but no more than three business days, or right away if an emergency occurs
Behavioral health provider	Urgent care	As member's health condition requires, but no more than 24 hours
	Routine care – initial assessment	Within seven calendar days
	Routine care – first visit after the assessment	As soon as needed based on a member's health condition, but: • Members 18 years old and older, no later than 23 calendar days from the date of the initial assessment • Members less than 18 years old, no later than 21 days after the initial assessment
	Routine care – services after first visit	Within 45 calendar days

Type of provider	Type of care	Wait time
	For psychotropic medications	Get an assessment immediately so that you don't run out of your medicine and your health isn't affected. If needed, you'll get an appointment as soon as possible, but no more than 30 calendar days

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

♀ Health care for women

There is no copay for women's preventative health services. Additionally, transportation services are available if needed. For questions regarding these services, assistance scheduling appointments for preventative care, or coordinating transportation contact Member Services at (800) 424-5891 (TTY/TDD: 711).

Well-Woman Preventative Care

An annual well-woman preventive care visit is intended for the identification of risk factors for disease, identification of existing physical/behavioral health problems, and promotion of healthy lifestyle habits essential to reducing or preventing risk factors for various disease processes.

You can expect the following services when seeing a provider for your annual preventative care visit:

- Physical exam (Well Exam) that assesses overall health,
- Clinical Breast Exam,

- Pelvic exam (as necessary, according to current recommendations and best standards of practice),
- Review and administration of immunizations, screenings, and testing as appropriate for age and risk factors
- Screening and counseling focused on maintaining a healthy lifestyle and minimizing health risks and addresses at a minimum the following:
  - Proper nutrition,
  - Physical activity,
  - Elevated BMI indicative of obesity,
  - Tobacco/substance use, abuse, and/or dependency,
  - Depression screening,
  - Interpersonal and domestic violence screening
  - Sexually transmitted infections,
  - Human Immunodeficiency Virus (HIV),
  - Family Planning Services and Supplies

- Preconception Counseling that includes discussion regarding a healthy lifestyle before and between pregnancies that includes:
  - Reproductive history and sexual practices,
  - Healthy weight, including diet and nutrition, as well as the use of nutritional supplements and folic acid intake,
  - Physical activity or exercise,
  - Oral health care,
  - Chronic disease management,
  - Emotional wellness,
  - Tobacco and substance use (caffeine, alcohol, marijuana, and other drugs), including prescription drug use, and
  - Recommended intervals between pregnancies, and
  - Initiation of necessary referrals when the need for further evaluation, diagnosis, and/or treatment is identified.

Early and Periodic Screening Diagnostic and Treatment (EPSDT)

Early Periodic Screening, Diagnostic and Treatment (EPSDT) is a comprehensive child health program of prevention and treatment, correction, and improvement (amelioration) of physical and behavioral health conditions for AHCCCS members under the age of 21.

The purpose of EPSDT is to ensure the availability and accessibility of health care resources, as well as to assist Medicaid recipients in effectively utilizing these resources.

EPSDT services provide comprehensive health care through primary prevention, early intervention, diagnosis, medically necessary treatment, and follow-up care of physical and behavioral health problems for AHCCCS members less than 21 years of age.

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

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

This means that EPSDT covered services include services that correct or ameliorate physical and behavioral health conditions, and illnesses discovered by the screening process when those services fall within one of the optional and mandatory categories of “medical assistance” as defined in the Medicaid Act.

Services covered under EPSDT include all 30 categories of services in the federal law even when they are not listed as covered services in the AHCCCS state plan, AHCCCS statutes, rules, or policies as long as the services are medically necessary and cost effective.

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

Well-child visits and immunizations are important for babies, children, and adolescents. Well-child visits help keep children and adolescents healthy and identify problems before getting sick by receiving age-appropriate preventative, dental, physical health, behavioral health, developmental, and specialty services. Immunizations help protect against many diseases. You can contact Member Services if you need assistance with scheduling appointments with your child's PCP or you are need of transportation assistance.

Well-Child visit schedule:

- Newborn
- 3-5 days
- 1 month
- 2, 4, 6, 9, 12, 15, 18, 24, and 30 months
- Annually from ages 3-20 years of age

The EPSDT/Well-Child visit includes the following:

- Comprehensive health and developmental history
- Nutritional screening and assessment
- Behavioral health screening and services
- Developmental screening
- Comprehensive physical examination
- Immunizations
- Laboratory tests
- Health education, counseling, and chronic disease self-management as appropriate to age and risk
- Oral health screening
- Appropriate vision, hearing, and speech screenings
- Tuberculosis (TB) screening as appropriate to age and risk

Immunizations (shots)

- Diphtheria, Tetanus, Pertussis (DTaP)
- Haemophilus Influenzae type b (Hib)
- Hepatitis A
- Hepatitis B
- Human Papillomavirus (HPV)
- Influenza (Flu)
- Measles, Mumps, Rubella (MMR)

- Meningococcal (Meningitis)
- Pneumococcal (Pneumonia)
- Inactivated Polio (IPV)
- Rotavirus (RV)
- Tetanus, Diphtheria, Pertussis (Tdap)
- Varicella (Chickenpox)

Care for pregnant members

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

If you think you may be pregnant, be sure to call Member Services at (800) 424-5891 (TTY/TDD: 711). We can help you set up an appointment with an OB/GYN, certified nurse midwife (CNM) or licensed midwife right away to start getting prenatal care.

It's important to choose a primary OB provider. Your primary OB will take care of all your pregnancy needs. Getting timely prenatal care, as soon as you suspect or you know that you may be pregnant, is important for you and your baby to stay healthy during pregnancy. You may choose to have your OB/GYN as your PCP if you want. If you have been receiving prenatal care prior to your enrollment date, be sure to confirm that your prenatal provider is in network. Members who transition to a new health plan or become enrolled during their third trimester are able to complete maternity care with their current AHCCCS registered provider to ensure continued care.

Member Services will assist you with your care concerns if your prenatal provider is out-of-network.

It is important that you go to each of your appointments. Some topics to discuss with your provider to decrease health risks to you and your baby include:

- Nutrition and lifestyle choices. You will need to adjust your diet during pregnancy to meet increased nutrient needs as your baby develops. Using tobacco, alcohol, some medications, opioids, and illicit drugs use, and risky behaviors such as those putting you at risk for injury or sexually transmitted diseases can impact your health during pregnancy as well as lead to health issues for your baby.

- Human immunodeficiency virus (HIV). HIV is a virus that attacks the immune system. It makes it hard for the body to fight infection and disease. Pregnant women with HIV can pass this virus on to the baby. Being tested during pregnancy can reduce the risk of passing HIV to the baby.
- Low birth weight. Monitoring the intrauterine growth and development of a fetus throughout pregnancy is important to reduce risks that babies may have when born earlier or at a low weight. Some, not all, of the risks after birth may include feeding problems, breathing problems, developmental delays, intellectual delays, infections, vision or hearing problems.
- Lead exposure. Lead is a toxic metal found in many products. Lead can be easily ingested, inhaled, or absorbed by our bodies. People do not always experience illness when exposed. Lead in pregnant women is passed on to the baby and may increase the risk for premature delivery, as well as directly damage a baby's heart, kidneys, nervous system, and may result in learning or behavior problems. Prevention and avoiding exposure is the best action. If discovered early, it may be possible to reduce or eliminate exposure and decrease further damage.
- Delivery options and associated risks and benefits. You do have choices related to delivery options. Explore the benefits and risks of options for you and your health status during pregnancy with your provider. Babies born at or after 39 weeks have the best chance at healthy outcomes compared with babies born before 39 weeks.
- Active labor. It is important to know when you are experiencing normal active labor such as feeling the baby dropping lower in abdomen, increase in vaginal discharge, and types of contractions. Your provider can provide you with the next steps to minimize the risk of complication in advance, preparing you for when this time comes.
- Breastfeeding. Breastfeeding provides essential nutrition and is known to provide some protection against common childhood infections and lowers risk of infant death from sudden infant death syndrome (SIDS). For mothers, breast feeding can help reduce weight gain from pregnancy and some cancers, type 2 diabetes, and high blood pressure are less common among women who breastfeed. Your provider and community resources such as the ADHS Breastfeeding Hotline are available to assist with breastfeeding challenges, use of medications, and managing return to school/work.
- SIDS is a sudden unexplained death of an infant. Place infants on a firm surface on their backs to sleep. Infants sleeping on their backs are less likely to die of SIDS. Avoid using soft bedding, pillows, stuffed animals, waterbeds in the crib.

- Depression. Talk to your provider if you are having feelings of anxiety, loss of enjoyment in things that you previously enjoyed, cry or weep frequently, are unable to sleep, not feeling connected to your developing baby, or other feelings of sadness or stress. It is not uncommon to have symptoms of depression during pregnancy or during the postpartum period. If you are feeling suicidal, call the suicide hotline immediately for assistance.

Prenatal care appointment time frames:

Time frame	When you can get an appointment
First trimester	Within 14 days of request for appointment
Second trimester	Within seven days of request for appointment
Third trimester	Within three days of request for appointment
High-risk pregnancy	Within three days, or immediately if it is an emergency

It's important to go to each of your appointments. You'll have appointments before your baby is born (prenatal), and then also after your baby is born (postpartum). You and your healthcare provider should schedule your postpartum appointment within three weeks of your delivery, sooner if you have a cesarean section or high-risk conditions.

Even if you don't feel sick, make sure you go to your appointments so your provider can see how you and your baby are doing.

At your postpartum checkup, your doctor will:

- Make sure you're healing
- Check you for postpartum depression
- Do a pelvic exam to make sure reproductive organs are back to pre-pregnancy condition
- Answer questions about breastfeeding and do a breast exam
- Answer any questions about having sex again and your birth control options

If you have experienced a miscarriage, stillbirth, or neonatal death, it is essential to ensure follow-up with your obstetric care provider.

HIV testing and counseling services for men and women

MCC covers HIV testing for both men and women at no cost to you. If your test is positive, there is treatment and medical counseling available to you through your health plan benefits.

Talk to your PCP or contact your local health department to get tested.

Family planning services and supplies for men and women

Family planning services and supplies can help protect you from having an unwanted pregnancy or from getting a sexually transmitted infection (STI). All members of reproductive age regardless of gender can get family planning services and supplies without a referral at no cost.

These are available from your PCP, your OB/GYN, family planning providers listed in our provider directory, like Planned Parenthood offices statewide.

You do not need a referral for family planning services from PCPs, OB/GYN and family planning providers. You can get services from these providers even if they are out of network. If your provider is not in our network, please call Member Services.

Assistance scheduling a family planning visit and medically necessary transportation are available if needed. Contact Member Services for additional information, assistance to obtain or schedule an appointment, or questions about transportation to and from health care appointments.

Examples of family planning services and supplies include:

- Contraception counseling and interconception health counseling
- Associated medical and laboratory examination and radiological procedures
- Birth control pills
- Birth control shot given every three months
- Intrauterine devices (IUD) and implantable contraceptives
- Diaphragm (a vaginal removable barrier worn by women)
- Natural family planning education or referral to qualified health professionals
- Screening for STIs
- Condoms. Foams, Suppositories
- Long-Acting Reversible Contraceptives (LARC) including Immediate Postpartum Long-Acting Reversible Contraceptives (IPLARC)
- Emergency contraception pill (pill taken after unprotected sex to prevent pregnancy)
- Family planning counseling
- Tubal ligation (sterilization for women ages 21 and older)
- Vasectomy (sterilization for men ages 21 and older)

Call Member Services at (800) 424-5891 (TTY/TDD: 711) Monday-Friday 8 a.m. to 6 p.m. MST for a full list of family planning services and supplies.

It's important to stay safe, even if you lose your health benefits. If you lose your eligibility for AHCCCS services, we can help you find low-or no-cost family planning services. You don't need a referral before choosing a family planning provider.

Here are some resources available that can help you:

Resource	Contact information
Planned Parenthood	(800) 230-7526
Arizona Department of Health Services Hotline	(800) 833-4642
Arizona Department of Health	(602) 542-1025
Arizona Family Health Partnership	(602) 258-5777 or (888) 272-5652

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 benefits

We believe giving you or your child access to good dental care is important to your health. Covered services include regular and routine dental services like preventive dental check-ups, cleaning, x-rays, fillings and other services to check for any changes or problems that may need treatment or follow-up care. The type of care you get depends on your age at the time you receive the care.

Children dental services

A child's first visit to a dentist for a dental examination is recommended to begin by age one. Repeat preventative follow-up should continue every six months as indicated by the child's risk status or susceptibility to disease. Members under the age of 21 do not require a referral for preventive dental care and there is no co-pay for preventive dental care visits.

If you are or your child is under the age of 21, you or your child will be given a dental home. A dental home means that you or your child has an assigned dentist who works with you to provide all dental care needs, as needed. The dental home will also:

- Complete dental care
- Create a dental health plan designed for you
- Give you guidance about diet and growth
- Give you information on how to correctly care for your teeth

If you or your child needs to see a specialist, the dental home will work with you to set up your or your child's care.

We will assign you a dental home when you enroll with us. If your child is less than 12 months old, we will assign them a dental home before his or her 1st birthday.

We will send you or your child a notice in the mail with the name and location of your dental home. You can call Member Services at (800) 424-5891 (TTY/TDD: 711) to choose or change your dental home or provider at any time.

Regular dental care is an important part of being healthy. We want you to get the care you need. You will get notices when you or your child has an upcoming dental screening, as well as reminders when a dental screening is overdue.

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Adult dental services

If you are 21 years of age or older, Molina Complete Care will cover dental services only in emergency situations. The following services are some of the emergency benefits we cover:

- Oral examination that focuses on the specific tooth or mouth pain
- X-ray of the painful tooth or teeth
- Resin used to seal a recent tooth fracture
- Removal of the painful tooth
- Prefabricated crown used to eliminate tooth pain on a recent tooth fracture
- Root canal when needed to stop an infection or eliminate pain

These services are covered up to $1,000 benefit for each member every year.

Dental appointments

To make an appointment, call your dentist. If you need help making an appointment or finding a dentist, call Member Services at (800) 424-5891 (TTY/TDD: 711). Make sure to keep your dental appointments.

If you need to change or cancel an appointment, call the dentist or dental home as soon as you can.

When you go to the dentist, show your Molina Complete Care member ID card. There is not a separate MCC dental ID card.

How to get your medicines

For new medicines

When you get a prescription from your doctor, ask him or her to send your prescription to a pharmacy near you that works with MCC. You'll find this list in the provider directory at www.MCCofAZ.com.

Or you can take the prescription to the pharmacy and drop it off yourself.

For medicines you already take

If you already have medicines at a pharmacy that's not on our list, you'll need to choose a new pharmacy from the list of those we work with. Ask your new pharmacy to get your prescription from your old pharmacy.

If you need your medicine right away

If you've had an emergency and need a medicine filled after hours or on a weekend or holiday, you may use any one of MCC's in-network pharmacies. Our list of pharmacies shows which ones are open 24 hours a day.

If MCC is not paying for your medication, your pharmacy may call the 24-hour pharmacy help desk at (800) 424-5891 (TTY/TDD: 711) to ask if the medication is eligible for an emergency override.

If you're having trouble getting your medicine at the pharmacy

If you're at the pharmacy (sometimes called a point of sale) and you can't get your medicine, your pharmacy can call MCC at (800) 424-5891 (TTY/TDD: 711). Do not pay for your medicine on your own.

Some drugs have limits or require the doctor to get approval before you can get the drug.

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Pharmacy/provider restrictions

MCC monitors controlled and non-controlled medicines on a regular basis. We want you to stay safe and healthy, so if you use multiple pharmacies or medicines, you might be assigned to use just one pharmacy, one provider, or assigned one provider and one pharmacy for all of your prescriptions.

This might happen if:

- You use four or more pharmacies, and
- You use four or more doctors and four or more medications included on the monitored list, or
- You have filled 12 or more controlled prescriptions in the last three months.

If you are assigned to one pharmacy and/or provider, we will send you a letter letting you know why along with information on how to file a State Fair Hearing and the time frame and process for doing so. You have 30 calendar days from the date of the letter to request a State Fair Hearing.

Please mail your written request for a State Fair Hearing to:

Molina Complete Care
Attn: Appeals and Grievance Department
5055 E Washington St, Suite 210
Phoenix, AZ 85034

If you need help filing an appeal or have questions about this information, please call Member Services at (800) 424-5891 (TTY/TDD: 711) Monday-Friday 8 a.m. to 6 p.m. MST.

Behavioral health services

We know that staying healthy means that you get access to health care for your body and mind. With your AHCCCS Complete Care benefits, you get physical and behavioral health services.

MCC's behavioral health benefit includes mental health and substance use disorder outpatient visits (office or telehealth based), psychological and neuropsychological testing, psychiatric home health, inpatient behavioral health, inpatient substance use treatment, residential treatment programs and may include services through an opioid treatment program. Additionally, behavioral health benefits may provide inpatient and outpatient behavioral health for beneficiaries. Members may access these services directly by a self-referral or through provider referrals. Members may also call (800) 424-5891 (TTY/TDD: 711) and request to speak to a care manager for assistance with their behavioral health questions.

Serious mental illness evaluation and determination

MCC has contracted providers who complete Serious Mental Illness (SMI) evaluations:

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- A member, family member, provider or any community agency must ask for an SMI evaluation and there is no copay.
- You must be at least 17 1/2 years old to have an SMI evaluation.
- The provider doing the SMI evaluation will get a written consent from you or your health care decision maker before the test.
- You or your health care decision maker will get information on your rights and the appeal process.
- To get SMI services, you must have both a qualifying SMI diagnosis and functional impairment, which is caused from the diagnosis.

How to get SMI services?

Anyone can refer or you can self-refer for an SMI evaluation. You can ask to be considered for SMI by your:

- Behavioral health care manager
- Provider
- Health plan
- A Tribal Regional Behavioral Health Authority (TRBHA)
- The Arizona Department of Corrections Rehabilitation and Reentry (ADOCRR)
- The Arizona Department of Juvenile Corrections (ADJC)
- Solari Crisis & Human Services.
- Hospital Inpatient Team

If you are already getting services from an AHCCCS provider, you may ask your provider to submit an application for SMI services.

MCC has in-network providers who are qualified to conduct SMI evaluations. If you or a health care decision maker needs help finding a qualified provider, please call Member Services at (800) 424-5891 (TTY/TDD: 711). Once you ask for an SMI evaluation, the qualified provider will schedule an appointment for you. Your appointment will be scheduled no later than seven (7) business days from the date you called and asked for the evaluation.

If you are in an inpatient psychiatric hospital, the hospital staff can help you ask for an SMI evaluation. The SMI evaluation will happen while you are in the hospital. Information from your stay will be used to complete your SMI determination.

After the evaluation is completed, the provider will submit all information to Solari. Solari is a statewide provider that performs SMI eligibility determinations throughout Arizona.

Solari will send you a letter in the mail, within three (3) business days from the date you met with the qualified provider to complete the evaluation to let you

know the final decision on your SMI evaluation. This is called a Notice of Decision. If you are not determined to be SMI-eligible, this letter will tell you why. You have the right to appeal this decision. To file an appeal, please contact Solari by phone at (855) 832-2866. You can also write them and mail your appeal to:

Solari Crisis and Human Services
1275 West Washington Street
Suite 210
Tempe, AZ 85281

The Notice of Decision letter will include information about your member rights and how to appeal the SMI decision.

If the member is determined SMI, MCC will work with the responsible Regional Behavioral Health Authority (ACC-RBHA) to make sure you have a smooth transition.

Members with SMI and who are enrolled in one health plan for both physical health and behavioral health services, may request a different plan for their physical health services. This is called an opt-out process. A member can only request to opt-out for certain reasons. To ask for an opt-out, the member shall show harm or unfair treatment in:

1. Getting health care,
2. Receiving quality health care,
3. Protecting member privacy and rights, or
4. Choosing a provider.

If you would like to ask for an opt-out, contact Member Services at (800) 424-5891 (TTY/TDD: 711) Monday-Friday 8 a.m. to 6 p.m. MST.

If the member is not determined SMI, they will stay with MCC for all covered behavioral health services.

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:

1. Easy access to care,
2. Behavioral health recipient and family member involvement,
3. Collaboration with the Greater Community,
4. Effective Innovation,
5. Expectation for Improvement, and
6. Cultural Competency.

The 12 principles for the delivery of services to children:

1. Collaboration with the child and family:
   a. Respect for and active collaboration with the child and parents is the cornerstone to achieving positive behavioral health outcomes, and
   b. Parents and children are treated as partners in the assessment process, and the planning, delivery, and evaluation of behavioral health services, and their preferences are taken seriously.

2. Functional outcomes:
   a. Behavioral health services are designed and implemented to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults, and
   b. Implementation of the behavioral health services plan stabilizes the child's condition and minimizes safety risks.

3. Collaboration with others:
   a. When children have multi-agency, multi-system involvement, a joint assessment is developed and a jointly established behavioral health services plan is collaboratively implemented,
   b. Client-centered teams plan and deliver services, 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 Division of Child Safety (DCS) and/or Division of Developmental Disabilities (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 that incorporate evidence-based "best practices."
    c. Behavioral health service plans identify and appropriately address behavioral symptoms that are related to: learning disorders, substance use problems, specialized behavioral health needs of children who are developmentally disabled, history of trauma (e.g. abuse or neglect) or traumatic events (e.g. death of a family member or natural disaster), maladaptive sexual behavior, abusive conduct and risky behaviors. Service plans shall also address the need for stability and promotion of permanency in class member's 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.

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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 preference—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 Clinic (MSIC)

An MSIC is a clinic where specialists from different specialties meet with children and their families to provide complete care.

There are different types of providers and services at the MSIC, including:

- Family practice—this is a primary care provider
- Physical therapy—therapy to help you treat pain through movement and exercises
- Occupational therapy—therapy to help you learn or relearn everyday activities
- Speech therapy—therapy to help you learn to speak, swallow and eat
- Audiology—providers who treat hearing loss and hearing conditions
- Plastic surgery—providers who help repair and reconstruct a person's skin
- Orthopedics—providers who treat bones and joints
- Neurology—providers who treat things related to the nervous system and your brain

How to make, change or cancel an appointment at an MSIC

To make an appointment at an MSIC, call the phone number listed for the office. Let them know what type of appointment your child needs, and they'll help schedule your child's appointment.

Make sure you keep your appointment. Write it down on your calendar or make a note so you remember the date and time. If something comes up and you aren't able to see the provider on that day, call as soon as you know to reschedule your appointment.

If you need help making your appointment or need help getting a ride to your visit, call Member Services at (800) 424-5891 (TTY/TDD: 711).

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MSICs who work with MCC

DMG Children's Rehabilitative Services
3141 N 3rd Avenue
Phoenix, AZ 85013
(602) 914-1520
(855) 598-1871
www.dmgcrs.org

Children's Clinics
Square & Compass Building
2600 North Wyatt Drive
Tucson, AZ 85712
(520) 324-5437
(800) 231-8261
www.childrensclinics.org

Children's Rehabilitative Services
1200 North Beaver
Flagstaff, AZ 86001
(928) 773-2054
(800) 232-1018
www.flagstaffmedicalcenter.com

Children's Rehabilitative Services
Tuscany Medical Plaza
2851 S Avenue B, Suite
25 Yuma, AZ 85364
(928) 336-7095
(800) 837-7309
www.yumaregional.org

Children's Rehabilitative Services (CRS) program

What is CRS?
Children's Rehabilitative Services (CRS) is a designation given to certain AHCCCS members who have qualifying health conditions. Members with a CRS designation can get the same AHCCCS-covered services as non-CRS members, and are able to get care in the community or in clinics called multi-specialty interdisciplinary clinics (MSIC).

MSICs bring many specialty providers together in one location. Your health plan will assist a member with a CRS designation with closer care coordination and monitoring to make sure special health care needs are met.

Eligibility for a CRS designation is determined by the AHCCCS Division of Member Services (DMS).

Who is eligible for a CRS designation?
AHCCCS members may be eligible for a CRS designation when they are:

- Under age 21
- Have a qualifying CRS medical condition

The medical condition must:

- Require active treatment
- Be found by AHCCCS DMS to meet criteria as specified in R9-22-1301-1305

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

- A completed CRS application
- Medical documentation that supports that the applicant has a CRS qualifying condition that requires active treatment

MCC will give medically necessary care for physical and behavioral health services and care for the CRS condition.

Member Advisory Committee (MAC)

The Member Advisory Committee (MAC) is a group of members, member families and community organizations. They work together to better understand your needs.

Your feedback helps improve the benefits and services you get from MCC. The MAC meets once a month to talk about:

- Member communications and materials
- Access to health care services.
- Resources
- And more!

We are always looking for new members who want to help us make MCC a better health plan for all members. Your experience, knowledge and point of view is very important to us.

Join the MAC and let your voice be heard!

The MAC application is online at www.MCCofAZ.com > Members.

If you want to join MAC, email MCCAZ-OIFA@molinahealthcare.com. You can also call Member Services at (800) 424-5891 (TTY/TDD: 711).

Request for approval of care

There are some treatments, services and drugs that you need to get approval for before you get them or continue receiving them. This is called a prior authorization. You, your doctor, or someone you trust can ask for a prior authorization. An approval helps let us know if certain services or procedures are medically needed.

MCC discusses some services with your providers before you get them to make sure they are appropriate and needed. Your provider will help you in getting a service authorized from MCC when services need to have an authorization in place.

Some examples of services that need prior authorization are outpatient surgeries, medical supplies (i.e. wheelchairs), a stay in the hospital, pain management, transplants, orthotics and prosthetics. If you have any questions about what needs a prior authorization, call Member Services at (800) 424-5891 (TTY/TDD: 711).

Many services don't need an authorization. MCC does not reward providers or our own staff for denying coverage or services.

Decisions are based on what is right for each member and on the type of care and services that are needed.

We look at standards of care based on:

- Medical policies
- National clinical guidelines
- Medicaid guidelines
- Your health benefits

Molina Complete Care does not reward employees, consultants, or other providers to:

- Deny care or services that you need
- Support decisions that approve less than what you need
- Say you don't have coverage

An authorization is not a guarantee of payment. Members must be eligible at the time services are rendered. Services must be a covered health plan benefit and medically necessary with a prior authorization as per plan policy and procedures. It is the responsibility of the member/provider to check for changes in the prior authorization requirements.

After we get your request

MCC has a review team to be sure you receive medically necessary services. Doctors and nurses are on this team. Their job is to be sure the treatment or service you asked for is medically needed and right for you. They do this by checking your treatment plan against medically acceptable standards.

The standards we use to determine what is medically necessary are not allowed to be more limiting than those that are used by AHCCCS. Any decision to deny a service authorization request or to approve it for an amount that is less than requested is called an adverse benefit determination (decision). These decisions will be made by a qualified health care professional.

If we decide that the requested service is not medically necessary, the decision will be made by a medical or behavioral health professional who may be a doctor or other health care professional that typically provides the care you requested.

You can request the specific medical standards, called clinical review criteria, used to make the decision for actions related to medical necessity.

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After we get your request, we will review it under a standard or expedited (fast) review process. You or your doctor can ask for an expedited review if you think that a delay will cause serious harm to your health.

If your request for an expedited review is denied, we will tell you and your case will be reviewed under the standard review process.

Information on restrictions on freedom of choice

You have the right to choose what provider you work with. See the *Your primary care provider* section and the *Seeing a specialist* section to find out how to find a provider. Sometimes providers may not be accepting new patients because they have already reached their patient limit. In this case, we'll work with you to help you find a provider who is accepting new patients.

Copayments

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

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

The following persons are not asked to pay copayments:

- Children under age 19,
- People determined to have a Serious Mental Illness (SMI),
- An individual designated eligible for Children's Rehabilitative Services (CRS) pursuant to as A.A.C Title 9, Chapter 22, Article 13.,
- ACC, ACC-RBHA and CHP members who are residing in nursing facilities or residential facilities such as an Assisted Living Home and only when member's medical condition would otherwise require hospitalization. The exemption from copayments for these members is limited to 90 days in a contract year,
- People who are enrolled in the Arizona Long Term Care System (ALTCS),
- People who are Qualified Medicare Beneficiaries,
- People who receive hospice care,
- American Indian members who are active or previous users of the Indian Health Service, tribal health programs operated under Public Law 93-638, or urban Indian health programs,
- People in the Breast and Cervical Cancer Treatment Program (BCCTP),
- People receiving child welfare services under Title IV-B on the basis of being a child in foster care or receiving adoption or foster care assistance under Title IV-E regardless of age,
- People who are pregnant and throughout postpartum period following the pregnancy, and
- Individuals in the adult Group (for a limited time**).

****NOTE:** For a limited time, persons who are eligible in the Adult Group will not have any copays. Members in the Adult Group include persons who were transitioned from the AHCCCS Care program as well as individuals who are between the ages of 19 –64, and who are not entitled to Medicare, and who

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are not pregnant, and who have income at or below 133 percent of the Federal Poverty Level (FPL) and who are not AHCCCS eligible under any other category. Copays for persons in the Adult Group with income over 106 percent FPL are planned for the future. Members will be told about any changes in copays before they happen.

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

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

People with optional (non-mandatory) copayments

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

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

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

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

Ask your provider to look up your eligibility to find out what copays you may have. You can also find out by calling Molina Complete Care member services. You can also check the Molina Complete Care website for more information.

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

Optional (non-mandatory) copayment amounts for some medical services

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

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

People with required (mandatory) copayments

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

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

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Required (mandatory) copayment amounts for persons receiving TMA benefits

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

Pharmacists and Medical Providers can refuse services if the copayments are not made.

5 percent Limit on all copayments

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

AHCCCS will track each member's specific copayment levels to identify members who have reached the 5 percent copayment limit. If you think that the total copays you have paid are more than 5 percent of your family's total quarterly income and AHCCCS has not already told you this has happened, you should send copies of receipts or other proof of how much you have paid to *AHCCCS, 801 E. Jefferson, Mail Drop 4600, Phoenix, Arizona 85034*.

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

If you get non-covered services

We cover your services when you are enrolled with our plan and:

- Services are medically necessary
- Services are listed as Benefits Covered through MCC in the Covered Benefits section of this handbook
- You receive services by following plan rules

If you get services that aren't covered by our plan or covered through AHCCCS, you must pay the full cost of these services yourself. If you are not sure and want to know if we will pay for any medical service or care, you have the right to ask us.

You can call Member Services at (800) 424-5891 (TTY/TDD: 711) or your care manager to find out more about services and how to get them.

You also have the right to ask for this information in writing. If we say we will not pay for your services, you have the right to appeal our decision. The Appeals section of this handbook provides instructions for how to appeal MCC's coverage decisions.

You may also call Member Services to learn more about your appeal rights or to get help filing an appeal.

If you get a bill for services

You should never be billed for covered services. If you get a bill for a covered service:

- **Do not pay the bill yourself**
- Call the provider's office and give them your insurance information and ask them to bill us

If you continue to get bills or if you pay a bill, call Member Services at (800) 424-5891 (TTY/TDD: 711) or write us and let us know. We will contact the provider and tell them to stop billing you and get your money back. If you want to write us, mail your letter to:

Molina Complete Care
5055 E Washington St,
Suite 210
Phoenix, AZ 85034

When can you be billed for services?

If you agree to pay for services that are not covered by us, talk to your doctor about payment options. If you ask for a service that is not a covered benefit and you sign a statement agreeing to pay the bill, you will have to pay the bill.

Third-party liability

Members enrolled in Medicaid, determined by AHCCCS as having comprehensive health coverage other than Medicare, will be eligible for enrollment in the Complete Care program, as long as no other exclusion applies.

Members who have Medicare or any other health insurance after enrollment in the Complete Care program stay enrolled in the program.

MCC will help coordinate all covered benefits with any other insurance carriers you may have (as applicable) and follow Medicaid "payer of last resort" rules.

The "payor of last resort" rules means that we'll cover your deductibles and coinsurance up to the maximum allowable reimbursement amount that would have been paid if you didn't have another insurance plan.

When the Third-Party Liability (TPL) payer is a commercial MCO/HMO organization, that MCO/HMO is responsible for the full member copayment amount. You won't have to pay for any Medicaid-covered services.

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Medicare and other insurance

If you have other insurance or Medicare, make sure you let us know. This doesn't change the benefits you will get from your AHCCCS Complete Care plan but will let us help you understand your benefits.

If you have Medicare or other insurance, your PCP will be assigned by that plan. We will help you coordinate your care between your other health insurance and your MCC benefits.

Members who have AHCCCS and Medicare are called "dual eligible." MCC may help pay your coinsurance and deductibles if you use Medicare providers that are in the MCC network.

Tell your doctor if you have other insurance and bring all of your member ID cards to your appointments. Your other insurance or Medicare is your primary insurance. You must use your primary insurance first. Do not pay the provider directly. If you pay for AHCCCS-covered services directly, we won't be able to reimburse you.

Medicare drug coverage

AHCCCS does not pay for any cost-sharing, coinsurance, deductibles, or copays for medications that are eligible for coverage under Medicare Part D. AHCCCS may cover drugs that are excluded from coverage under Medicare Part D based on medical necessity.

Medicaid does not cover medications that are eligible for coverage under Medicare Part D plans. Medicaid does not pay for Medicare copayments, deductibles or cost sharing for Medicare Part D medications except for persons who have been designated to have an SMI designation. AHCCCS covers medications that are excluded from coverage under Medicare Part D when those covered medications are deemed medically necessary. An excluded drug is a medication that is not eligible for coverage under Medicare Part D. AHCCCS may cover some mediations that are Over-the-Counter (OTC), refer to the MCC OTC Drug List for a list of products available on our website https://www.molinahealthcare.com/members/az/en-us/-/media/Molina/PublicWebsite/PDF/members/az/en-us/AZ-Member-Formulary-Drug-File_-ENG_508c.pdf or call Member Services to request a printed copy.

Prior Authorizations

MCC decides if a service that needs a prior authorization will be covered based on the information given by your provider. Prior authorization does not guarantee payment to your provider. Payment is based on the accuracy of the information from your provider. Your provider will tell you if your service is approved. If the service is denied, MCC will send you a letter called a Notice of Adverse Benefit Determination.

Decisions about prior authorizations are made based on whether or not a doctor has an urgent request for service. An urgent request for service would be used if the standard time frame could affect your life or health. The decision would be made within 72 hours.

If it is a standard request for services, it would be completed as quickly as your condition requires, but no later than 14 calendar days from the date of the request.

Pharmacy prior authorization requests are made no more than 24 hours from the date of the request.

MCC may extend the time frame on your behalf to make a prior authorization decision for standard and expedited service requests when the member or provider (with written consent of the member) asks for an extension. MCC may also extend the time frame if we justify the need for additional information to make a decision.

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Time frames for service authorizations

Standard requests involving medications

MCC issues service authorizations for medicines no later than 24 hours from the time we get the request. This applies even if the due date falls on a weekend or a holiday. If we need more information, we will ask for it from the prescriber within 24 hours. The final decision will be sent no later than seven business days from the date of the request.

Standard requests not involving medications

MCC issues service authorizations on requests that are not related to prescriptions as quickly as needed, but no later than 14 calendar days from the initial request. If we need more information to make a decision, we may issue a notice of extension for an extra 14 calendar days.

Molina expedited requests not involving medications

MCC issues expedited service authorizations as quickly as the member's health condition requires, but no later than 72 hours from the date of receipt. This applies even if the date falls on a weekend or legal holiday. We may issue a notice of extension for an extra 14 calendar days if the criteria for service authorization extension are met.

For information on what we used make this decision, please call Member Services at (800) 424-5891 (TTY/TDD: 711). You can call Monday-Friday 8 a.m. to 6 p.m. MST.

If the request doesn't qualify for an expedited review, it becomes a standard request. If you disagree, you may file a grievance either by calling Member Services or mailing to:

Molina Complete Care
Attn: Grievance and Appeals
5055 E Washington St, Suite 210
Phoenix, AZ 85034

If we do not meet the time frames for making a decision, your request is denied. You will get a Notice of Adverse Benefit Determination (NOA). This letter will explain your rights to file an appeal.

If you disagree with the adequacy of the NOA, you can file a complaint by calling Member Services or mailing to:

Molina Complete Care
Attn: Grievance and Appeals
5055 E Washington St, Suite 210
Phoenix, AZ 85034

You may also contact AHCCCS Medical Management at: MedicalManagement@azahccs.gov if MCC does not resolve your concern of adequacy with the NOA letter.

For information about the prior authorization process, time frames for making a decision and your rights, please call Member Services at (800) 424-5891 (TTY/TDD: 711). You can call Monday-Friday 8 a.m. to 6 p.m. MST.

Grievances, appeals and State Fair Hearings

Your right to file a grievance

If you are not happy with us, your provider, or your services for any reason, you or someone who can act for you can tell us. We want to hear from you. The problem or concern you are calling about will be handled as a grievance (another word for complaint). There are several ways you can file a grievance:

By phone: Call Member Services at (800) 424-5891 (TTY/TDD: 711) Monday-Friday 8 a.m. to 6 p.m. MST.

By email: Email MCCAZ-CustomerSvc@molinahealthcare.com

By mail: Send a letter to:
Molina Complete Care
Attn: Grievance Coordinator 5055 E Washington St, Suite 210
Phoenix, AZ 85034

Call us if you need help with filing a grievance.

Grievance process

MCC will send you a letter to let you know we received and are working on your grievance. We will try our best to deal with your concerns as quickly as possible. We will resolve your issue within 10 business days and send you a letter with our answer.

If we need information, we may take up to 90 days to resolve the grievance.

If your complaint is about a Notice of Adverse Benefit Determination sent to you by MCC, or you don't understand the notice, MCC will do a review to make sure it is clear and correct. If it is not correct, we will send a corrected notice.

The time frame for your appeal and continuation of services will start from the date of the corrected notice.

External grievance process

You can make a complaint about MCC to AHCCCS Medical Management by sending an email to MedicalManagement@azahcccs.gov. You can file a complaint about MCC with MCC or AHCCCS.

You can make a complaint to the Department of Health and Human Services' Office for Civil Rights if you think you have not been treated fairly. For example, you can make a complaint about disability access or language assistance. You can also visit www.hhs.gov/ocr for more information.

Office of Civil Rights- Region III
Department of Health and Human
Services 150 S Independence Mall
West Suite 372 Public Ledger Building
Philadelphia, PA 19106

(800) 368-1019
Fax: (215) 861-4431
TDD: (800) 537-7697

Your right to appeal

If we do not give your doctor an okay for a service, or if a service is reduced or ended, we will send you a Notice of Adverse Benefit Determination (refer to the Authorization Request section of this handbook) that tells you why.

If you disagree with our decision, you can file an appeal asking us to take a second look. We will not treat you or your provider unfairly because you file an appeal.

Some reasons you might file an appeal are:

- You received a denial of services—this could be either a full or partial denial
- Care that was previously approved has been reduced or stopped
- You received a denial of payment for a service—either whole or in part
- You did not get services in a timely manner
- Your grievance, appeal or request for a State Fair Hearing was not completed in the stated time frame
- Members in a rural area did not get the out-of-network provider approval and there is no other provider in the rural area

How to file an appeal

You can file an appeal within 60 days of the date on the Notice of Adverse Benefit Determination (this is the letter you will get from us in the mail). There are several ways you can file an appeal:

By phone: Call Member Services at (800) 424-5891 (TTY/TDD: 711) Monday-Friday 8 a.m. to 6 p.m. MST.

By email: Email MCCAZ-CustomerSvc@molinahealthcare.com

By mail: Send a letter to:
Molina Complete Care
Attn: Grievance Coordinator
5055 E Washington St, Suite 210
Phoenix, AZ 85034

If you call us, you must also write to us within 10 days unless you are asking for an expedited appeal. If you choose to have someone else (like a family member or your provider) file the grievance on your behalf, we will need your written permission.

Call us if you need help with filing an appeal.

Standard appeal process

We will send a letter to let you know we have received and are working on your appeal. Appeals of clinical matters will be decided by qualified health care professionals who did not make the first decision and who have experience in the area of your condition or disease.

The services that you are getting may continue if you file the appeal within 10 days of the date on the Notice of Adverse Benefit Determination or by the date the change in services is scheduled to happen. If your appeal results in another denial and AHCCCS agrees with our decision, you may have to pay for the cost of any continued benefits that you received.

Before and during the appeal, you or your authorized representative can provide more information and see your case file, including medical records and any other documents being used to make a decision on your case. This information is available at no cost to you.

If we have all the information we need, we will make our decision within 30 days of when we get your appeal request. A written letter, called a Notice of Appeal Resolution, with our decision will be sent within three business days from when we make the decision.

You can ask for an extension of up to 14 days. Or MCC may request an extension for up to 14 days if we need more information.

We will call you to tell you and send written notice within two calendar days of the reason for the decision to extend the time frame.

You have the right to file a grievance if you disagree with the extension.

If you do not agree with MCC's decision on your appeal, you can request a State Fair Hearing.

Expedited appeals

If you need a decision right away, please let us know it is urgent. This happens when your health status is in danger. If we have all the information we need, we will give you an answer within 72 hours of your request. While you wait for our answer, you can continue to get care.

However, if the final decision is not in your favor, you may have to pay for the care. We will tell you our decision by phone and send a written Notice of Appeal Resolution within one business day from when we make the decision.

If we decide that your appeal should not be expedited, we will call you to tell you and send written notice within two calendar days of the reason for the decision. MCC will then resolve your appeal within the standard appeal time frames.

If you do not agree with MCC's decision on your appeal, you can request for an expedited State Fair Hearing.

State Fair Hearing request

If you do not agree with MCC's decision of your appeal, you or your authorized representative can ask for a State Fair Hearing in writing within 90 days from the date you get on the Notice of Appeal Resolution letter from us.

Information about how to ask for a State Fair Hearing will come with the Notice of Appeal Resolution letter.

To ask for a State Fair Hearing in writing, you can send a letter to:

Molina Complete Care Attn:
Appeals Coordinator
5055 E Washington St, Suite 210
Phoenix, AZ 85034

AHCCCS will send you information about next steps in a Notice of Hearing. The services that you are getting may continue if you request a State Fair Hearing within 10 days of the date on the appeal decision letter from MCC.

We will not treat you or your provider unfairly because you file request a State Fair Hearing.

MCC will send AHCCCS information about your case. If AHCCCS decides that MCC's decision was correct, you may have to pay for services you received during the State Fair Hearing process.

If AHCCCS decides that our decision was not correct, MCC will authorize and pay for services promptly.

Filing a grievance, appeal, or request for hearing with the Regional Behavioral Health Authority (ACC-RBHA)

Members may file complaints, grievances and appeals for services (for example: crisis services, SMI services, etc.) provided by the ACC-RBHA directly with the ACC-RBHA.

Members may file an SMI grievance or request an investigation alleging that a rights violation or a condition requiring investigation has occurred or currently exists. (Please note: allegations about the need for, or appropriateness of behavioral health services should not be considered an SMI grievance, but should be addressed through the appeal process described below.) The request may be verbal or written and must be initiated no later than one year after the date of the alleged rights violation or condition requiring investigation. Forms for filing are available at AHCCCS, the Arizona State Hospital, the T/RBHAs, case management sites and at all provider sites.

Allegations of rights violations by a TRBHA or their providers or SMI grievances/requests for investigation related to physical or sexual abuse or death will be addressed by AHCCCS. All other SMI grievances/requests for investigation must be filed with and addressed by the appropriate RBHA. Within 7 days of the date received, you will be sent an acknowledgment letter and, if appropriate, an investigator will be assigned to research the matter. When a decision is reached, you will receive a written response.

Any person, age 18 or older, his or her guardian, or designated representative, may file an appeal related to services applied for, or services the person is receiving. Matters of appeal are generally related to: a denial of services; disagreement with the findings of an evaluation or assessment; any part of the Individual Service Plan; the Individual Treatment and Discharge Plan; recommended services or actual services provided; barriers or unreasonable delay in accessing services under Title XIX; and fee assessments. Appeals must be filed with the RBHA (or AHCCCS for the TRBHAs) and must be initiated no later than 60 days after the decision or action being appealed. Appeal forms are available at AHCCCCS, the T/RBHAs, case management sites and at all provider sites.

The RBHA (or AHCCCS for TRBHA appeals) will attempt to resolve all appeals within seven days through an informal process. If the problem cannot be resolved, the matter will be forwarded for further appeal. If the RBHA will not accept your appeal or dismisses your appeal without consideration of the merits, you may request an Administrative Review by AHCCCS of that decision.

For SMI grievances/requests for investigation and appeals, to the greatest extent possible, please include:

1. Name of person filing the SMI grievance/request for investigation or appeal
2. Name of the person receiving services, if different.
3. Mailing address and phone number.
4. Date of issue being appealed or incident requiring investigation.
5. Brief description of issue or incident.
6. Resolution or solution desired.

For either process above, you may represent yourself, designate a representative, or use legal counsel. You may contact the State Protection and Advocacy System, the Arizona Center for Disability Law (800) 922-1447 in Tucson and (800) 927-2260 in Phoenix. You may also contact the Office of Human Rights at (602) 364-4585, or (800) 421-2124 for assistance. If your

complaint relates to a licensed behavioral health agency, you may contact the Office of Behavioral Health Licensure, 150 N. 18th Avenue, Phoenix, Arizona 85007, (602) 364-2595.

Arizona's Three Regional Behavioral Health Authorities

Mercy Care Grievance System Department
4500 E. Cotton Center Blvd.
Phoenix, AZ 85040
(602) 586-1719 or (866) 386-5794
https://www.mercycareaz.org/members/ltc-formembers/grievance

Arizona Complete Health – Complete Care Plan
Attn: Grievance and Appeals Department
1870 W. Rio Salado Parkway
Tempe, AZ 85281
(888) 788-4408 or TTY/TDY 711
https://www.azcompletehealth.com/providers/resources/grievance-process.html

Care1st Health Plan Arizona, Inc.
Claim Disputes and Appeals Department
1870 West Rio Salado Parkway
Tempe, AZ 85281
(602) 778-1800 or (866) 560-4042, TTY: 711
https://www.care1staz.com/az/healthplans/what-to-do-c1st.asp

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

What to expect as an MCC member

Member rights

You have the right to:

A. Ask about the structure and operation of MCC or our subcontractors.
B. Ask about how Molina pays providers, controls costs and uses services.
C. To know if stop-loss insurance is required.
D. Be treated fairly, no matter your:
   - Race.
   - Ethnicity.
   - National origin.
   - Religion.
   - Gender.
   - Age.
   - Behavioral health condition.
   - Intellectual or physical disability.
   - Sexual preference.
   - Genetic information.
   - Source or ability to pay.

E. Have your treatment and information kept private. We share records without your okay only when the law allows it.
F. Help make decisions about your health care. This is the right to:
   - Get a second medical opinion from a provider within the network. Or get a second opinion outside the network at no cost.
   - To say no to treatment. This is your right unless the court says otherwise.

G. Learn about treatment options and in a way that:
   - Respects your culture.
   - You can understand.
   - Fits your needs.

H. Get an emergency or replacement caregiver when they are late or a no-show.

I. Get written information on advance directives and your rights under state law. We can get you information on how to make your own advance directive. (An advance directive tells doctors the kind of care you would want if you become too sick to decide).

J. Request and get a copy of your medical records at no cost once a year:

- If there are any changes needed to your medical records, you may ask for these changes at any time.
- We'll respond to the request within 30 days. We'll either give you the medical records or send a letter stating why the request was denied. If you are denied, we'll tell you how to get the decision reviewed.

K. Be free from any form of restraint or seclusion as a mean of coercion, discipline, convenience or retaliation.

L. To get beneficiary and health plan information by calling Member Services.

M. Be treated carefully, with respect and privacy for dignity and privacy.

N. Take part in making your care plan. You also have the right to refuse treatment.

O. Get information in a language you can understand. Know about providers who speak languages other than English. Get things translated at no-cost.

P. Get treatment for any emergency at any hospital or other setting. An emergency is when a problem may lead to more harm if you don't get care right away.

Q. Get information in other ways if you ask for it.

R. Get information about MCC and its:

- Providers.
- Programs.
- Services.
- Role in the treatment process.

S. Get information about clinical rules followed in your care.

T. Get care easily and when you need it.

U. Ask your providers about their work history and training.

V. Not be kept alone or forced to do something you do not want to do. This is based on the law.

W. Give your thoughts on the Rights and Responsibilities policy.
X. Ask for a certain type of provider.
Y. Have your provider make care decisions based on the treatment you need.
Z. Get health care services that obey the laws about your rights.

AA. File a complaint or grievance about:
- Molina Complete Care.
- A provider.
- The care you get.

BB. File an appeal about a Molina action or decision. You can ask for a State Fair Hearing if you are not happy with the appeal decision.

CC. Sign a form saying you know your health information may be shared during a State Fair Hearing. This applies if your provider asks for the hearing for you. Your provider will need you to sign this form.

DD. Use your rights. This will not affect the way Molina and its providers treat you.

EE. Talk with your provider about the types of treatment that are right for you. The cost or benefit coverage do not affect this.

FF. Get information about how and where to get benefits from the state that are not covered under your plan. This could include cost-sharing. It could also include transportation.

GG. Ask for information in a way that you can get to it easily. This applies if you have a visual, hearing or physical disability. This will help you know what benefits and services you have.

HH. Get information about MCC, its services, its providers and your rights and responsibilities.

II. Ask for information about a doctor's contract, incentive plans or other compensation, use of referrals, member survey results and if stop-loss insurance is required. To get this information, please call Member Services at (800) 424-5891 (TTY/TDD: 711).

JJ. Use your rights. Using your rights will not adversely affect service delivery 42 CFR 438.100(c).

Member responsibilities

You have the responsibility to:

A. Get treatment you need from a provider.

B. Respect anyone giving you care.

C. Give providers and MCC the information they need. This helps you get good care. It helps us give you the right care.

D. Ask questions about your care. This helps you and your providers understand your health problems. It helps you make treatment goals and plans you agree on.

E. Follow your care plan. You and your provider should agree on this plan.

F. Follow the plan for taking your medicine. You and your provider should agree on the plan.

G. Tell your providers and PCP about changes in your medicine. This includes medicines other doctors give you.

H. Come to all your provider visits. Call your provider as soon as you know you need to cancel a visit.

I. Tell your provider when you think the care plan is not working.

J. Tell your provider if you have problems paying copays.

K. Share your worries about the quality of your care.

L. Report if you think someone is not being honest. This may be abuse or fraud.

- Call the Molina AlertLine. You can call 24 hours a day and 7 days a week. You do not have to give your name when you call.
- All calls will be looked into and stay private.
- You can report fraud, waste and abuse:
  - By calling the AlertLine: (866) 606-3889
  - Online: www.molinahealthcare.alertline.com
- You may also report fraud, waste and abuse to the state or federal government.

Fraud, waste and abuse

What is fraud, waste and abuse?

- Fraud refers to a false action that is used to gain something of value
- Waste is the misuse of services
- Abuse refers to overused or unneeded services

We are dedicated to conducting business in a legal manner. We are committed to preventing, detecting and reporting fraud, waste and abuse. Also, the AHCCCS Office of Inspector General (AHCCCS OIG) wants to prevent fraud, waste and abuse.

They check on anybody including members, providers and vendors who may be trying to commit fraud, waste or abuse against the Medicaid program. Under law, there is a penalty for fraud and abuse. They also:

- Recover overpayments
- Issue warnings
- Send possible fraud cases for investigation

Examples of fraud, waste and abuse include:

- Medical services that are not needed
- Billing for services that were not provided
- Billing for services not covered by Medicaid
- Billing twice for the same service
- Using a billing code to get extra payments
- Using another person's identity to get Medicaid services
- Making false documents by changing:
  - The date of service for a claim
  - Prescriptions
  - Medical records
  - Referral forms
- Paying or taking a bribe

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How to report fraud, waste and abuse

If you think someone or a provider is committing fraud, waste and abuse, please report it.

Callers do not have to give their names. All calls will be investigated. All calls will remain confidential.

- AlertLine: (866) 606-3889
- Online: www.molinahealthcare.alertline.com
- Molina Complete Care Special Investigation Unit at (877) 269-7624

Help quitting tobacco

We have resources to help you quit using tobacco. These resources provide you support in quitting for good.

ASHLine – Arizona Smokers' Helpline

A no-cost phone and online resource 24/7 to help you quit tobacco. Call (800) 556-6222 (TTY/TDD: 711) or visit www.ashline.org to get help.

With this resource, you get:

- A no-cost coach to talk to about quitting tobacco
- Access to online resources
- Text message coaching to get help right from your phone

Tobacco Free Arizona

Visit this helpful Arizona Department of Health Services website to find more about the Tobacco Free Arizona campaign. You'll find out more about the program and tools to help you quit.

Visit www.azdhs.gov/prevention/tobacco-chronic-disease/tobacco-free-az/index.php to use the tools and resources.

Local and online resources

Resource	Contact Information
Health-e-Arizona Plus: This is the online site where you can learn about, sign up for and manage your AHCCCS benefits and services. You can also update your contact information on this site.	www.healthearizonaplus.gov
AZ Links: This is an online resource for seniors, people with disabilities and caregivers to help connect to resources to plan for the future and immediate needs.	www.azlinks.gov
Women, Infants and Children (WIC): A nutrition program for pregnant or breastfeeding women, infants and children under five years of age that meet certain low-income requirements. WIC helps families learn about eating well and staying healthy.	(800) 252-5942
Head Start and Early Head Start: Head Start is a program that gives low-income children and family support in: • Early childhood education (pre-school) • Nutrition • Health and social services Early Head Start is a program for low-income pregnant teens and teen families with infants and toddlers.	(866) 763-6481 www.azheadstart.org

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Resource	Contact Information
Arizona Early Intervention Program (AzEIP): This program can help you find services for children from birth to age three who may have disabilities or developmental delays.	www.des.az.gov/services/disabilities/developmental-infant **Central office:** (602) 532-9960
Arizona Autism Coalition: The Arizona Autism Coalition improves the lives of individuals with Autism Spectrum Disorder and their families in Arizona by sharing resources through statewide collaboration and advocacy.	www.azautism.org
Area Agency on Aging: Programs and services developed for older Arizona residents.	**Maricopa County:** (602) 264-2255 www.aaaphx.org **Pinal and Gila Counties:** (800) 293-9393 www.pgcsc.org
The Alzheimer's Association: A national non-profit that offers support and resources for those affected by Alzheimer's and other dementias.	**24/7 Helpline:** (800) 272-3900 www.alz.org
AZ Suicide Prevention Coalition: This group works to promote suicide awareness and intervention.	www.azspc.org (602) 248-8337

Resource	Contact Information
National Alliance on Mental Illness (NAMI): This national mental health organization works to help those dealing with mental illness. NAMI can also help you connect with an attorney in your area.	NAMI Helpline: (800) 950-NAMI www.nami.org
Dump the Drugs AZ: This is an online tool that lets you find locations to safely get rid of any unwanted prescription drugs.	www.azdhs.gov/gis/dump-the-drugs-az/
National Suicide Prevention Lifeline The National Suicide Prevention Lifeline is a national network of local crisis centers that provide no-cost and confidential emotional support to people. . The National Suicide Prevention Lifeline is available 24 hours a day, 7 days a week.	www.suicidepreventionlifeline.org/ **24/7 Lifeline:** (800) 273-8255
Teen Lifeline This is a lifeline to help young people in Phoenix and throughout Arizona who are having an emotional crisis or are thinking about suicide.	**Maricopa County:** (602) 248-8336 (TEEN) **Outside Maricopa County:** (800) 248-8336 (TEEN) **Outside Arizona/Nationally:** (877) YOUTHLINE or (800) SUICIDE
AHCCCS Federally Qualified Health Care Centers and Rural Health Clinics	www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/FQHC-RHC.html

Resource	Contact Information
Local Federally Qualified Health Centers (FQHCs)	Adelante Healthcare, Inc. Circle the City Valleywise Health Horizon Health & Wellness (formerly Mountain Health & Wellness) Mountain Park Health Center Native Health Neighborhood Outreach Action for Health (N.O.A.H.) Sun Life Family Health Center Terros, Inc Valle Del Sol, Inc. Wesley Community Center
Power Me A2Z This is a no-cost program from the Arizona Department of Health Services (ADHS) that offers approved multivitamins by the ADHS. The ADHS mails them to female members to help improve their health.	www.powermea2z.org
Arizona Department of Health Services' 24-Hour Breastfeeding Hotline Get help and answers to any breastfeeding questions 24 hours a day, 7 days a week.	**24/7 Hotline:** (800) 833-4642 www.azdhs.gov/prevention/nutrition-physical-activity/breastfeeding/index.php

Resource	Contact Information
Birth to Five Helpline This is a no-cost service available to all Arizona families with young children looking for the latest child development information from health care professionals.	(877) 705-KIDS (5437) Bilingual childhood specialists are available Monday-Friday 8 a.m. to 8 p.m. MST. You can also leave a voicemail, text the Helpline 24 hours a day, 7 days a week or fill out the online contact form for help.
Fussy Baby The Fussy Baby program provides support for parents who are concerned about their baby's development during the first year of life. Fussy Baby clinicians work with families to explore ways to soothe, care for, and enjoy your baby.	(877) 705-KIDS (5437)
Maricopa County Lead Poisoning Prevention Provides information on lead hazards and lead poisoning prevention.	(602) 525-3162
Arizona Poison Control This is a no-cost, confidential helpline is available 24 hours a day, 7 days a week. You should call if: • You think someone has been poisoned • Someone has taken too many drugs or unknown medicines • You need to know more about a drug • You or your pet has been stung or bitten by a poisonous creature • You need information about preventing accidental poisonings	(800) 222-1222 www.azpoison.com

Resource	Contact Information
Raising Special Kids Raising Special Kids helps to improve the lives of children with the full range of disabilities, from birth to age 26 by offering support, training, information and individual help so families can best support their children.	www.raisingspecialkids.org/ (800) 237-3007
Strong Families AZ This is a network of no-cost home visiting programs that helps families raise healthy children. Programs focus on pregnant women and families with children birth to five years old.	www.strongfamiliesaz.com/
Postpartum Support International Postpartum Support International offers direct peer support to women dealing with postpartum depression.	www.postpartum.net/ **Call:** (800) 944-4773 (Press "1" for Spanish or "2" for English) **Text:** (503) 894-9453 (English) or (971) 420-0294 (Spanish)
2-1-1 Arizona This is a no-cost service available 24 hours a day, 7 days a week. 2-1-1 Arizona will help individuals and their families find local resources.	www.211arizona.org/ **Call:** 2-1-1 within Arizona or (877) 211-8661 from anywhere
Vocational Rehabilitation The Vocational Rehabilitation program offers employment services to people with disabilities.	www.des.az.gov/services/employment/rehabilitation-services/vocational-rehabilitation

Resource	Contact Information
ARIZONA @WORK Helps employers find, develop and keep the best employees. ARIZONA@WORK is a resource and tool for job seekers and employers throughout the state of Arizona and aims to strengthen Arizona's economy and workforce. The ARIZONA@WORK services assist job seekers through internet job search tools, access to job specialists, editing resumes, locating job fairs, identifying training, wage and earning resources, unemployment/ insurance benefit resources, and a additional no-cost workforce services for job seekers to obtain gainful employment.	www.arizonaatwork.com
Arizona Opioid Assistance & Referral (OAR) Line • 24/7 no-cost, confidential service • Staffed with certified nurses and pharmacists • Providers and prescribers can talk to a physician	www.azdhs.gov/oarline/ (888) 688-4222
Arizona Disability Benefits 101 (DB101) DBO101 helps people with disabilities and service providers understand the connections between work and benefits.	www.az.db101.org

Resource	Contact Information
Arizona Peer and Family Coalition The mission of the Arizona Peer & Family Coalition is to advocate for, connect, promote and develop leadership by peers and family members throughout Arizona.	www.azpeerandfamily.org
AHCCCS Office of Individual and Family Affairs (OIFA) OIFA promotes recovery, resiliency and wellness for people struggling with mental health and substance use.	www.azahcccs.gov/AHCCCS/HealthcareAdvocacy/OIFA.html
Community Legal Services Community Legal Services offers: • Legal help and education • Representation • Self-help materials They focus on helping with: • Domestic abuse survivors • Consumer fraud and abuse victims • Employment problems o o Wage issues	www.clsaz.org (602) 258-3434 (800) 852-9075 TTY: (602) 254-9852

Pyx Health App

Sign up for the Pyx Health program and get connected to the help you need to stay happy and healthy. There's no cost to you.

Search "Pyx Health" in the Apple App store or Google Play Store or go to www.HiPyx.com
Questions? Call (855) 499-4777

If you lose your AHCCCS eligibility, you may still get primary and preventive care at low or no cost. Go to www.MCCofAZ.com > Members > Helpful Resources > Local Resources for a list of low- or no-cost services. You can also call Member Services for help at (800) 424-5891 (TTY/TDD: 711) Monday-Friday 8 a.m. to 6 p.m. MST.

Advocacy resources

Here are some resources that you can contact to help promote your health and access to health care. Advocacy groups help promote your rights. They help you understand your rights as a member and patient.

To use these resources, call the number or visit the website listed. If you need help contacting one of these groups, call Member Services at (800) 424-5891 (TTY/TDD: 711).

Resource	Contact Information
Arizona Center for Disability Law—Mental Health: This is a non-profit law firm that helps Arizona residents with disabilities promote and protect with legal rights	(800) 927-2260 www.azdisabilitylaw.org
Arizona Coalition to End Sexual and Domestic Violence: Get information and answers to questions about sexual and domestic violence services in Arizona. This includes the legal system, your legal rights, resources and safety planning	(800) 782-6400 www.acesdv.org/
Children's Action Alliance: Non-profit organization that has been advocating for children for more than 30 years	(602) 266-0707 www.azchildren.org

Phoenix Family Advocacy Center: Network of advocacy centers that provide services to victims of sexual and domestic violence	(602) 534-2120 www.acfan.net/centers/phoenix-family.htm
Child Help USA: Center that provides services to address the immediate safety and well-being of children who have been abused and/or neglected	(602) 271-4500 www.childhelp.org
National Alliance on Mental Illness (NAMI): The nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness	(888) 999-6264 www.nami.org
Arizona Coalition Against Sexual and Domestic Violence: Formed in 1980 so that concerned citizens and professionals could unite in a statewide organization to end domestic violence	(800) 782-6400 www.acesdv.org/

Protected health information

Molina Complete Care follows the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the federal law for Confidentiality of Substance Use Disorder Patient Records (42 CFR Part 2). We have rules to protect your health information (PHI).

This includes oral, written and electronic PHI. Examples of information that will be protected:

- Member name
- Member ID number
- Social Security number
- Date of birth
- Member address
- Member telephone
- Health status
- Name of the doctors that provide you care

The Notice of Privacy Practices lists your rights under HIPAA. You have the right to see, correct and get copies of your PHI. MCC can use PHI for health plan activities. This includes paying doctor bills or the care we give you.

We may have to share this information if required by state or federal law.

If you qualify for care management, your care manager will go over the Authorization to Use and Disclose Information (AUD) form. This form asks if you want to share your information with other people to coordinate all of your health care.

Your care manager will give you the form or you can call Member Services. You can cancel your permission at any time.

If you need help with completing the form, please call Member Services toll free at (800) 424-5891 (TTY/TDD: 711).

Release of information on sensitive conditions

Release of information about protected and sensitive conditions and services, including substance use treatment, hepatitis C, HIV/AIDS and

psychotherapeutic services need specific release from you prior to sharing with other providers.

The Molina Complete Care Authorization to Use and Disclose Protected Health Information (AUD) form is used to indicate the conditions for which release is permitted. This form can be found at www.MCCofAZ.com.

School health services

Some school health services including certain medical, mental health, hearing or rehabilitation therapy services may be provided by local schools or other state agencies.

The law requires schools to provide students with disabilities a no-cost and appropriate public education, including special education and related services according to each student's Individualized Education Program (IEP). While schools are financially responsible for educational services, in the case of a Medicaid-eligible student, part of the costs of the services identified in the student's IEP may be covered by Medicaid.

MCC care managers will work with you, schools and state agencies to coordinate the delivery of these services. Contact your child's school, the state agency, or your care manager if you have questions about these services.

Coordination of care with other state agencies

MCC may coordinate your care with other state agencies as needed to ensure you get the best quality of care. Other state agencies may include but are not limited to:

- Arizona Department of Child Safety (DCS)
- Arizona Families F.I.R.S.T (Families in Recovery Succeeding Together)

- Arizona Department of Education (ADE), Schools or Other Educational Authorities
- Arizona Department of Economic Security/Rehabilitation Services Administration (ADES/RSA)
- Courts
- Correction systems

MCC will only release information that is about your care. Information about substance use, hepatitis C and HIV/AIDS will only be released if there is a signed consent form from you giving permission to release this information. MCC releases your information so we can make sure all parties involved have the same information. It also allows us to help you get additional services that are listed in your treatment plans.

More information is available at www.oig.hhs.gov/fraud or www.azahcccs.gov/Fraud/ReportFraud/.

Glossary of terms

Managed care terms

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

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

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

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

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

Emergency medical transportation—See EMERGENCY AMBULANCE SERVICES

Emergency ambulance services—Transportation by an ambulance for an emergency condition.

Emergency room care—Care you get in an emergency room. **Emergency services—**Services to treat an emergency condition. **Excluded services—**See EXCLUDED

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

- Above a limit
- Experimental
- Not medically needed

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

Habilitation services and devices—See HABILITATION

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

Health insurance—Coverage of costs for health care services.

Home health care—See HOME HEALTH SERVICES

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

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

Hospital outpatient care—Care in a hospital that usually does not require an overnight stay.

Hospitalization—Being admitted to or staying in a hospital.

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

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

Non-participating provider—See OUT OF NETWORK PROVIDER

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

Participating provider—See IN-NETWORK PROVIDER

In-network provider—A health care provider that has a contract with your health plan.

Physician services—Health care services given by a licensed physician.

Plan—See SERVICE PLAN

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

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

Pre-authorization—See PRIOR AUTHORIZATION

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

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

Prescription drug coverage—Prescription drugs and medications paid for by your health plan.

Prescription drugs—Medications ordered by a health care professional and given by a pharmacist.

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Primary care physician—A physician defined as an individual licensed as an allopathic (MD) or osteopathic physician (DO).

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

- Person licensed as an allopathic or osteopathic physician
- Practitioner defined as a physician assistant licensed
- Certified nurse practitioner
- Naturopathic physician for AHCCCS members under the age of 21 receiving EPSDT services.

The PCP must be an individual, not a group or association of individuals, such as a clinic.

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

Rehabilitation services and devices—See REHABILITATION

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

Skilled nursing care—Skilled services provided in your home or in a nursing home by licensed nurses or therapists.

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

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

Maternity care terms

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

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

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

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

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

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

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 15 and 25 respectively.

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

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

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

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

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

Discrimination is against the law

Molina Complete Care follows the law. We treat all people equally. We do not discriminate against anyone based on:

- Race
- Color
- National origin
- Age
- Disability
- Sex

We provide free help and services to people with disabilities. We want you to be able to communicate with us easily. We offer:

- Qualified sign language interpreters.
- Written information in many formats. These may include:
  - Large print
  - Audio
  - Accessible electronic formats
  - Other formats

We also provide free language services to people whose first language is not English. We offer:

- Qualified interpreters
- Information that is written in other languages

Contact us at (800) 424-5891 (TTY/TDD: 711) if you need any of these services.

If you believe we have not provided these services or discriminated in another way, you can file a grievance one of two ways at:

- (866) 606-3889
- www.molinahealthcare.alertline.com

You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights. You may do this online at https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf. Or you may do this by mail or phone.

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019
TTY/TDD: (800) 537-7697

Complaint forms are available online. You may find them at www.hhs.gov/ocr/office/file/index.html.

Help in other languages

English

ATTENTION: Language assistance services, free of charge, are available to you. Call (800) 424-5891 (TTY/TDD: 711).

Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (800) 424-5891 (TTY/TDD: 711).

Navajo

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee aká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, koj̨' hódíílnih (800) 424-5891 (TTY/TDD: 711).

Chinese

注意：我們可為您提供免費語言服務。請致電 (800) 424-5891 (TTY/TDD: 711)

Vietnamese

CHÚ Ý: Hiện có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Xin gọi số (800) 424-5891 (TTY/TDD: 711).

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-424-5891 رقم 711 والبكم الصم ه

Tagalog

PAUNAWA: May magagamit kang mga libreng serbisyo ng tulong sa wika. Tumawag sa (800) 424-5891 (TTY/TDD: 711).

Korean

주의: 언어 지원 서비스를 무료로 이용하실 수 있습니다. (800) 424-5891 (TTY/TDD: 711) 번으로 전화해 주십시오.

French

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (800) 424-5891, ATS 711.

German

HINWEIS: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer (800) 424-5891, Schreibtelefon (TTY/TDD): 711.

Russian

ВНИМАНИЕ: если Вы говорите на русском языке, то Вам доступны бесплатные услуги перевода. Звоните (800) 424-5891, TTY 711.

Japanese

注意：言語支援サービスを無料でご利用いただけます。
(800) 424-5891 (TTY/TDD: 711)までお電話ください。

Farsi

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما .بگیرید تماس
با. باشد می فر (TTY/TDD: 711) 424-5891 (800)

Amharic

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ (800) 424-5891 (መስማት ለተሳናቸው 711).

Serbo-Croatian

PAŽNJA: Usluge jezičke pomoći dostupne su vam besplatno. Nazovite (800) 424-5891 (TTY/TDD- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

Thai

โปรดทราบ: คุณสามารถขอบริการช่วยเหลือทางภาษาได้โดยไม่มีค่าใช้จ่าย โทร (800) 424-5891 (TTY/TDD: 711)

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