CHAPTER 2:

Member Eligibility and Member Services

Reviewed/Revised: 10/1/18, 9/23/19, 1/1/20, 12/1/20, 1/1/21, 5/1/21, 10/29/21, 2/4/22, 3/1/22, 4/15/22, 9/8/22, 11/1/22, 11/1/23, 1/1/24, 7/1/24

2.0 BCBSAZ HEALTH CHOICE MEMBER SERVICES DEPARTMENT

Our members and their medical care are very important to us. To ensure their needs are met, the BCBSAZ Health Choice Member Services Department coordinates all membership activities.

The Primary functions of the Member Services Department include but not limited to:

- Verification of member eligibility
- Primary care physician (PCP) assignment and changes
- General Health Plan questions
- Immediate Member issue resolution; referrals of other issues (grievances/complaints to quality management for further investigation and resolution.
- Providing translation services to our members when engaging with our Member Services Department.
- Guidance regarding Provider Responsibility of translation services please refer to Chapter 4 *Cultural Competency.*
- Conducting Member Satisfaction Surveys

The BCBSAZ Health Choice Member Services Department is available from 8:00 AM to 5:00 PM, Monday through Friday at (480) 968-6866 or (800) 322-8670. The Member Services Department is closed on the following holidays: New Year's Day, MLK Day, Memorial Day, 4th of July, Labor Day, Thanksgiving Day, Day after Thanksgiving, Christmas Eve, and Christmas Day.

2.1 AHCCCS ELIGIBILITY

The Department of Economic Security, the Social Security Administration, or the AHCCCS Administration determines AHCCCS eligibility. Individuals must meet eligibility requirements set forth by the State of Arizona to become eligible for benefits under AHCCCS. BCBSAZ Health Choice does not participate in the AHCCCS eligibility determination process.

BCBSAZ Health Choice is a *Health-e-Arizona* Participant. If a BCBSAZ Health Choice member needs to renew their AHCCCS medical benefits, they can come to BCBSAZ Health Choice, and we will assist them in completing their online application for Arizona Residents. We can also check the status of their application for them. Renewal is free and easy!

2.2 COVERED SERVICES THROUGH BCBSAZ HEALTH CHOICE

Members are eligible for covered services under the Title XIX/XXI program. A covered service must be medically necessary. Examples of the covered services are listed below; however, please refer to Chapter 1: Introduction to BCBSAZ Health Choice for a detailed list of covered and non- covered services.

For eligible members with AHCCCS health plans, the covered medically necessary services include:

- Doctor's visits / Well-Child Visits
- Specialist care, if necessary
- Hospital services
- Pregnancy care
- Prescriptions and medical supplies
- Laboratory and x-ray services
- 24-hour emergency medical care
- Family Planning Services, not to include pregnancy termination or pregnancy termination counseling
- Complete physical exams
- Immunizations
- Breast reconstruction after mastectomy
- Dental screening and treatment (for children under age 21)
- Eye Exams, prescriptive lenses and repairs or replacements of lenses and frames (for children under age 21)
- Chemotherapy and radiation
- Hospice Services
- Emergency dental services
- Hearing tests and hearing aids (for children under age 21)
- Behavioral health services including inpatient, outpatient, counseling, and detoxification. (A complete listing of behavioral health services is provided in the behavioral health section of this member handbook)
- Non-emergent and emergent medical transportation

Note: The covered services, limitations, and exclusions described in this manual are global in nature and are included to offer general guidance to our providers. The *AHCCCS Medical Policy Manual (AMPM)* contains additional information about covered services, limitations, and exclusions, and is available on the AHCCCS website at: https://www.azahcccs.gov/shared/MedicalPolicyManual/.

Benefit Changes

BCBSAZ Health Choice, under the direction of the AHCCCS Administration, does not pay for certain medical care for anyone who is 21 years old or older. If you are a Qualified Medicare Beneficiary, we will continue to pay your Medicare deductible and coinsurance for these services.

The medical services that are not covered are:

AHCCCS EXCLUDED BENEFITS TABLE (ADULTS AGE 21 AND OLDER)		
BENEFIT/ SERVICE	SERVICE DESCRIPTION	SERVICE EXCLUSIONS OR LIMITATIONS
Bone-Anchored Hearing Aid	A hearing aid put on a person's bone near the ear by surgery to carry sound	AHCCCS will not pay for Bone-Anchored Hearing AID (BAHA). AHCCCS will pay for supplies, care of the hearing aid, and repair of any parts.
Cochlear Implant	A small device put in a person's ear by surgery to help them hear better	AHCCCS will not pay for cochlear implants. AHCCCS will pay for supplies, care of the implant and repair of any parts.
Lower limb Microprocessor controlled joint/ Prosthetic	A device that replaces a missing part of the body and uses a computer to help move the joint	AHCCCS will not pay for a lower limb (leg, knee, or foot) prosthetic that includes a microprocessor (computer chip) that controls the joint.
Emergency Dental Service	Emergency services when you need immediate care for a bad infection or severe pain in your mouth. Effective 10/01/2017, AHCCCS will pay for emergency dental services for adults up to $1,000 per membership year (October 1 – September 30). A *Dental Emergency* is defined as "an acute disorder of oral health resulting in severe pain and/or infection as a result of pathology or trauma."	AHCCCS will not cover dental services. This includes emergency dental services unless it is a medical or surgical service related to dental (oral) care. Medically necessary emergency dental care is covered for persons age 21 years and older who meet the criteria for a dental emergency. The $1,000 dental emergency benefit does not cover diagnosis and treatment of TMJ, fixed bridgework to replace missing teeth or maxillofacial dental services (except for reduction of trauma). Treatment for tooth loss is limited.

Services by Podiatrist	Any service by a doctor who treats feet and ankle problems	AHCCCS only covers medically necessary podiatry services that are performed by a licensed podiatrist and ordered by a primary care provider or primary care practitioner.
Respite Care	Short-term or continuous services as a temporary break for caregivers	The number of respite hours available to adults and children under ALTCS benefits or behavioral health services is 600 within a 12-month period. The 12 months will run from October 1 to September 30 of the next year.
Physical Therapy	Exercises taught or provided by a physical therapist to make you stronger or help improve movement.	For individuals over the age of 21, outpatient physical therapy visits are limited to 15 per contract year to restore an individual to a particular skill or function and 15 visits per contract year to assist an individual to maintain a skill or function, or attain a skill or function never learned or acquired (Oct. 1 – Sept. 30). If you have Medicare, call us to find out how the visits will be counted.
Occupational Therapy		Outpatient Occupational therapy visits are limited to 15 outpatient occupational therapy visits when they are needed to **keep** a level of function or help **get** to a level of function, and 15 outpatient occupational therapy visits to **restore** a level of function per contract year (Oct. 1 – Sept. 30).

2.3 COVERED SERVICES THROUGH INDIAN HEALTH SERVICES – IHS

Members eligible through the Indian Health Services (IHS) will receive all services listed above at an IHS facility.

2.4 CO-PAYMENTS

AHCCCS Copayments (Copays):
Copays are amounts members pay directly to a provider for each item or service they receive at the time of a service. Copays can be mandatory (also known as required) or optional (also known

as nominal) as explained below. Certain services and populations are exempt from any copays which means that no mandatory or optional copays will be charged.
Below is a description of current AHCCCS copays.

Members in the Adult Group include persons who were transitioned from the AHCCCS Care program as well as individuals who are between the ages of 19-64, and who are not entitled to Medicare, and who are not pregnant, and who have income at or below 133% of the Federal Poverty Level (FPL) and who are not AHCCCS eligible under any other category.

Mandatory Copays (also known as "required"):
If a member has a mandatory copay, providers CAN deny services if the member does not pay the mandatory copay. There are certain services and populations which are exempt from any copays as described below, which means that no copay can be charged. Members who can be charged mandatory copays are persons in the:

- Transitional Medical Assistance (TMA) program- individuals who were receiving AHCCCS in the Caretaker Relative category who become ineligible due to the increased earnings.

Optional Copays (also known as "nominal"):
If a member has an optional copay, a provider CANNOT deny the service if the member is unable to pay the optional copay. There are certain services and populations that are exempt from any copays as described below, which means that no copay can be charged. Members who can be charged nominal copays are persons in the:

- A caretaker relative eligible under A.A.C. R9-22-1427 (A),
- Young Adult Transitional Insurance (YATI) for young adults who were in foster care
- State Adoption Assistance for Special Needs Children who are being adopted
- Receiving Supplemental Security Income (SSI) through the Social Security Administration for people who are age 65 or older, blind, or disabled
- SSI Medical Assistance Only (SSI MAO) for individuals who are age 65 or older, blind or disabled
- Freedom to Work (FTW)

Copays are not charged for the following services:

- Family planning services and supplies
- Pregnancy related health care including tobacco cessation treatment for pregnant women
- Emergency services
- Services paid on a fee-for-service basis
- Preventive services, such as well visits, immunizations, pap smears, colonoscopies, and mammograms
- Provider preventable services

Copays are not charged to the following persons:

- Children under age 19
- People determined to be Seriously Mentally Ill (SMI) by the Arizona Department of Health Services
- People enrolled in the Arizona Long Term Care System
- People enrolled in Children's Rehabilitative Services (CRS members)
- People eligible as Qualified Medicare Beneficiaries A.A.C. Title 9, Chapter 29
- People who are acute care members residing in nursing homes, or residential facilities when the acute care member's medical condition would otherwise require hospitalization. The exemption from copayments for acute care members is limited to 90 days in a contract year
- People who receive hospice care
- People enrolled in the Breast and Cervical Cancer program
- People who are pregnant and throughout the postpartum period following the pregnancy
- American Indian members who are active or previous users of the Indian Health Service, tribal health programs operated under P.L. 93-638, or urban Indian health programs
- People receiving Title IV-E Adoption Subsidy or Foster Care Assistance
- People receiving Title IV-B Child Welfare Services
- People in the Adult Group (for a limited time*) who are eligible under A.A.C. R9-22-1427(E)

* For a limited time persons who are eligible in the Adult Group will not have any copays. Members in the Adult Group include persons who were transitioned from the AHCCCS Care program as well as individuals who are between the ages of 19-64, and who are not entitled to Medicare, and who are not pregnant, and who have income at or below 133% of the Federal Poverty Level (FPL) and who are not AHCCCS eligible under any other category.

AHCCCS Copayments		
Service	**Population and Copay Amounts**	
	MANDATORY COPAYS	OPTIONAL COPAYS
	TMA (current)	**Other** (current)
Prescription Drugs (per drug)	**$2.30**	**$2.30**
*Office Visits	**$4.00**	**$3.40**
*Outpatient professional therapies	**$3.00**	**$2.30**
*Non-emergency surgery	**$3.00**	**None**
Inpatient Hospital Stay	**None**	**None**
Non-emergency use of the Emergency Room	**None**	**None**
Taxis for Non-emergency Medical Transportation in Pima and Maricopa Counties	**None**	**None**

* = Applies to primary care physician, specialist, or other health care provider visits not in a hospital Emergency Room setting.

5% Limit on All Copays
The amount of total copays cannot be more than 5% of the family's total income during a calendar quarter (January-March, April-June, July-September, and October-December). If this 5% limit is reached, no more copays will be charged for the rest of that quarter. AHCCCS has a process to track cost sharing. If a member thinks that the total copays, they have paid are more than 5% of the family's total quarterly income and AHCCCS has not already told them, the member should send copies of receipts or other proof of how much they have paid to:

AHCCCS
801 E. Jefferson
Mail Drop 4600
Phoenix, Arizona 85034

If a member's income or circumstances have changed, it is important to contact the eligibility office right away.

2.5 NON-EMERGENCY USE OF THE EMERGENCY ROOM

As part of the proposed copay request, all hospitals in Arizona will have their payments reduced by the copay amounts for Non-emergency use of the Emergency Room as described above. As such, it is expected that all hospitals will charge members in the Adult Group for Non-emergency use of the Emergency Room, upon CMS approval.

For additional information regarding copayment requirements, please visit the AHCCCS website at: https://www.azahcccs.gov/PlansProviders/RatesAndBilling/copayments.html

2.6 ELIGIBILITY VERIFICATION

In order to receive payment for covered services, it is critical that member eligibility is verified before providing services. If a patient presents as a BCBSAZ Health Choice member but has lost eligibility and you do not verify their status before providing services, payment will not be made.

As long as you are a contracted primary care provider with BCBSAZ Health Choice claims will not be denied if the member is not assigned to the provider or group on the date of service. However, members should update their PCP with Member Services.

BCBSAZ Health Choice has an Eligibility module within the secure provider portal for BCBSAZ Health Choice ACC and RBHA members, for information on our secure provider portals, visit www.HealthChoiceAZ.com, under the "Provider" section of our website.

BCBSAZ Health Choice Telephone Verification – You may also contact BCBSAZ Health Choice Member Services directly by dialing (480) 968-6866 or (800) 322- 8670.

Providers may use any one of several verification processes to obtain eligibility, enrollment, and Medicare/TPL information (if available) through the AHCCCS Administration directly:

- AHCCCS encourages verifications through a batch process (270/271), in which the provider sends a file of individuals to AHCCCS, which AHCCCS returns with information the following day. Information on that process can be obtained by calling the AHCCCS Help Desk at (602) 417-4451.
- AHCCCS has developed a Web application that allows providers to verify eligibility and enrollment using the Internet. Providers also can obtain Medicare/TPL information for a member.
    - To create an account and begin using the application, providers must go to AHCCCS (azahcccs.gov).
    - For technical support when creating an account, providers should call (602) 417-4451.
- The Medical Electronic Verification System (MEVS) uses a variety of applications to provide member information to providers. For information on MEVS, please contact EMDEON at https://www.changehealthcare.com/contact-us.
- The Interactive Voice Response system (IVR) allows an unlimited number of verifications by entering information on a touch-tone telephone.
- Providers may call IVR at: Phoenix: (602) 417-7200 All others: 1-800-331-5090
- If a provider cannot use the AHCCCS batch or web processes, IVR or EMDEON, for verification of eligibility or enrollment, the provider may call the AHCCCS Verification Unit. The unit is staffed from 8:00 a.m. to 5:00 p.m., Monday through Friday. Providers should be prepared to give the operator the following information:
    - Provider NPI (if applicable) or the AHCCCS Provider Registration number; and
    - Member's name, date of birth, and AHCCCS ID number or Social Security number; and c. Date(s) of service.

Primary Care Physicians (PCP's) can also refer to their monthly member roster. However, the roster represents your membership for the first day of the month only. Providers can also locate their member roster online through BCBSAZ Health Choice Provider Portal for ACC members and the Integrated Care Exchange (ICE) Portal.

2.7 AHCCCS ID CARD

Each AHCCCS eligible member is given a BCBSAZ Health Choice identification card that indicates the member's name and the member's AHCCCS identification number.

Providers should request the member's Health Plan identification card at the time of visit. **Services cannot be denied if the member does not have their ID card at the time of the appointment**. BCBSAZ Health Choice recommends you ask for a second form of identification for members not known to you.

If a member has lost their card, please direct them to call BCBSAZ Health Choice Member Services to request a new card.

2.8 HEALTH PLAN SELECTION

All AHCCCS members have the right to select their AHCCCS health plan. Individuals receive information on how to choose an AHCCCS health plan at the time of eligibility. If they do not select a health plan, they are automatically assigned to a health plan through the AHCCCS algorithm system.

2.9 PLAN CHANGES

Members are generally not allowed to change their health plan until their Annual Enrollment Choice (AEC) period, which occurs on the anniversary date of their enrollment. Only in certain circumstances may a member request a change outside of this timeframe. Plan change requests may be granted based on continuity of medical care. Most often these requests involve continuity of prenatal care or care due to a chronic disease. The Medical Director(s) or designee will make the plan change determination based on information provided by the provider.

2.10 PRIMARY CARE PHYSICIAN (PCP) SELECTION

BCBSAZ Health Choice contracts with General Practice, Family Practice, Internal Medicine, and Pediatric physicians to provide PCP services to enrolled BCBSAZ Health Choice members. If a member does not choose a PCP, the BCBSAZ Health Choice Member Services Department assigns the member to a PCP based on geographic location.

BCBSAZ Health Choice offers its members the freedom of choice in selecting a PCP within its network. There are instances when BCBSAZ Health Choice may restrict a member's choice of PCP. Examples include but are not limited to, when a member frequently changes their PCP, for medically necessary reasons or due to the location to the members' residence.

Primary Care Provider (PCP) change request for a Health Choice member. Please note that our procedures require the member to make a PCP change request. We are not able to process requests from providers without the members' permission. Should a provider receive a PCP change request from a BCBSAZ Health Choice member, whether verbal or in person, the member will need to make contact with the Plan to make the request.

The member can make that request by doing one of the following…

- Members can call Member services at 480-968-6866 *directly,* either from the provider office or their own phone
- Email Health choice at: HCHComments@azblue.com
- Members can log into their Member Portal account and complete the request online

You can reach out to your Provider Performance Representative with an additional questions.

Each new member enrolled with BCBSAZ Health Choice receives written notification of their PCP and Health Home by mail. Children also receive written notification of their Dental Provider.

In addition to the letter with provider assignment information, information on how to obtain a Member Handbook is provided. The Member Handbook is a resource that provides assistance for members on how to obtain health care services through BCBSAZ Health Choice as well as their rights and responsibilities.

2.11 PRIMARY CARE OBSTETRICIAN (PCO) SELECTION

Pregnant Members may choose a Primary Care Obstetrician (PCO). If the member does not choose, they are assigned to a PCO. The PCO is the primary source of care for these members. For more information on PCO assignments, please refer to Chapter 16: Family Planning, Maternal Health, and Children's Services.

2.12 NEWBORNS

All babies born to BCBSAZ Health Choice-eligible mothers are also deemed to be BCBSAZ Health Choice eligible and may remain eligible for up to one year if the newborn continues to reside with the mother and newborn and the mother continue to reside in Arizona.

Newborns receive separate AHCCCS ID numbers, and services for them must be billed separately using the newborn's ID. Services for a newborn that are included on the mother's claim will be denied.

2.13 OUT OF STATE COVERAGE

A recipient who is temporarily out of the state but still a resident of Arizona is entitled to receive AHCCCS benefits under one of the following conditions:

- Medical services are required because of medical emergency.
    - Documentation of the emergency must be submitted with the claims to BCBSAZ Health Choice.
- The recipient requires a particular treatment that can only be obtained in another state and prior approval is provided by BCBSAZ Health Choice.
- The recipient has a chronic illness necessitating treatment during a temporary absence from the state or the recipient's condition must be stabilized before returning to the state.
- Providers out of state must be willing to register with AHCCCS and bill BCBSAZ Health Choice for the services.

Services furnished to BCBSAZ Health Choice members outside the United States are not covered.

2.14 MEMBER ROSTERS

Member Rosters list PCP's or PCO's assigned members as of the first day of the month. PCP and PCO member rosters are available through the BCBSAZ Health Choice Provider Portal at www.HealthChoiceAZ.com under the "Provider" section of our website. Member Rosters list Home Health assigned members upon enrollment or change. Health Home member rosters are available through the RBHA "ICE" Portal.

For information on our secure provider portals, visit www.HealthChoiceAZ.com under the "Provider" side of our website.

If a member seeking care is not listed on your roster, please have the member call BCBSAZ Health Choice's Member Services Department at (480) 968-6866 or (800) 322- 8670 to change PCPs.

PCP/PCO Member Assignment Change: BCBSAZ Health Choice offers its members the freedom of choice in selecting a PCP within its network. There are instances when BCBSAZ Health Choice may restrict a member's choice of PCP. Examples include but are not limited to, when a member frequently changes their PCP, for medically necessary reasons or due to the location to member's residence.

Primary Care Provider (PCP) change request for a Health Choice member, **please note that our procedures require the member to make a PCP change request.** We are not able to process requests from providers without the members' permission. Should a provider receive a PCP change request from a Health Choice member, whether verbal or in person, the member will need to make contact with the Plan to make the request.

The member can make that request by doing one of the following…

- Members can call Member services at 480-968-6866 *directly,* either from the provider office or their own phone
- Email Health choice at: HCHComments@azblue.com
- Member can log into their Member Portal account and complete the request on-line

You can reach out to your Provider Performance Representative with an additional question.

PCP/PCO Member Disenrollment Providers may request a member be removed from his/her roster. This must be submitted in writing and signed by the physician, the provider must provide emergency services for a period of thirty (30) days from the notice or until the member is assigned and able to establish with a new PCP, whichever comes first. A copy of the notice needs to be provided to the member and BCBSAZ Health Choice.
Rather than remove these members from your roster, we prefer to collaborate with you in managing their health care. Depending on the issue, BCBSAZ Health Choice will either contact the member directly or coordinate with our Case Management Department to attempt to

resolve the issue. It is important for your office to continue providing care to the member during this process. If no improvement is achieved after our interventions, it may be agreed that the member needs a new primary care physician. Member removal from your roster should be considered as a last resort.

Member assignment changes are effective the first of the month following notification. You can fax both provider and member letters to (480) 760-4708, Attention Member Services.

2.15 MEMBER RIGHTS

All Health Choice Providers are expected to review and adhere to the Member Rights as outlined below.

MEMBER RIGHTS

As a BCBSAZ Health Choice Member, you have the right to:

- Choose a primary care provider (PCP) and other providers from the BCBSAZ Health Choice network list. This also includes the right to refuse care from providers.
- You have the freedom of choice among providers within the BCBSAZ Health Choice network.
- Complain about BCBSAZ Health Choice. This complaint or appeal can be filed with BCBSAZ Health Choice or AHCCCS. You cannot be denied services if you file a complaint.
- Request information on the structure and operation of BCBSAZ Health Choice or its subcontractors.
- Request information on whether or not BCBSAZ Health Choice has Provider Action Plans (PIP) that affect the use of referral services, the right to know the types of compensation arrangements BCBSAZ Health Choice uses, the right to know whether stop-loss insurance is required and the right to a summary of member survey results, in accordance with PIP regulation.
- Be treated fairly when getting medical care. This means you have equal access to all BCBSAZ Health Choice services. BCSAZ Health Choice does not discriminate against any member based on race, ethnicity, national origin, religion, gender, age, behavioral health condition (intellectual) or physical disability, sexual orientation, genetic information, or ability to pay. All members also have the right to exercise his or her rights and that the exercise of those rights shall not adversely affect service delivery to the member [42 CFR 438.100(c)].
- Confidentiality and your privacy are important to us. Please see the Notice of Privacy Practices included in your Member Welcome Kit for information on how we handle medical information.
- A second opinion from a qualified health care professional within the network or have a second opinion arranged outside of the network, only if there is not adequate in-network coverage, at no cost.

- Receive and discuss information on available treatment options and alternatives, regardless of cost or benefit coverage; presented in a manner appropriate to your condition and in a way you can understand.
- Create a plan that tells health care providers what kind of treatment you do or do not want if you become too sick to make your own health care decisions. These are called “advance directives." We can give you information to help you create your own advance directives.
- You have the right to get other information, such as:
    - How to get after-hours and emergency services
    - Available treatment options (including the option of no treatment)
    - Prior authorization, referrals or any special procedures needed to get medical services
    - How to get mental health or substance abuse services
    - How to get services outside the BCBSAZ Health Choice service area
    - How to get covered services that are not offered or available through the health plan
    - The right to family planning services from an appropriate registered provider
    - A description of how the organization evaluates the appropriate use of new developments in medical technology and new applications of existing technologies for inclusion as a covered benefit.
    - New medical devices and procedures are evaluated by BCBSAZ Health Choice medical management team to:
        - Keep abreast of ongoing changes in medical technology
        - Ensuring our members have safe, effective, and evidence-based care
        - Review information from the appropriate governmental regulatory bodies such as U.S. Food and Drug Administration (FDA)
        - Obtain input from specialists and professionals with unique knowledge about the specific technology reviewed
- To maintain compliance with all Federal and State regulatory bodies and Accrediting agencies applicable to BCBSAZ Health Choice plans
- Information about grievances, appeals and requests for a hearing
- Inspect your medical records at any time. You have the right to ask for a copy of your medical records at least annually. There is no cost to you
- You have the right to a written reply from BCBSAZ Health Choice within 30 days of your request for medical records
- If denied, you have the right to information about why your request was denied
- You have the right to seek review of a denial in accordance with 45 CFR Part 164.
- You have the right to change or correct your medical records
- Request restrictions
- Private communications
- Accounting of disclosures
- A paper copy of the Notice of Privacy Practices. See the “Your Privacy” section of this handbook for more information.

- You have the right to make recommendations regarding the organization's member rights and responsibilities policy
- Ask for information about BCBSAZ Health Choice such as:
  - Its services
  - Its practitioners and providers
  - The plan's provider incentive program: This means you can ask about ways that the health plan pays our providers. Providers or other health care professionals are not financially rewarded based on denial of care or for limiting services.
  - Its quality improvement program including member survey results for the health plan
- Get health care services in accordance with access to care and quality standards
- Be sure BCBSAZ Health Choice will not hold it against you if you choose to use any of your rights
- Be free from any form of control or isolation used as a means of force, authority, convenience, or retaliation. You cannot be held against your will. You cannot be forced to do something you do not want to do. This also means you have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- Receive information on beneficiary and plan information
- Privacy and to be treated with respect and dignity
- Understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible
- Make decisions about your health care. This includes agreeing to treatment. It can also include the right to refuse treatment
- Have services and materials provided in a way that helps you understand. This may include help with:
  - **Language Needs:** Language services are available to you at no cost. This includes interpretation and translation. It also includes having materials translated into your own language. This includes having materials translated into your own language. We can help you find providers who speak your language. If your provider does not speak your language, they will arrange an interpreter for your medical appointments. This is provided at no cost to you. Talk to your provider about language services.
  - **Visual Needs:** This may include recorded materials, such as a CD, or materials in Braille. You can also ask for larger print. This is provided at no cost to you. Call Member Services for more information.
  - **Hearing Needs:** If you are deaf or hard of hearing, you can call Arizona Relay Services at 711. This telephone relay, or TTY/TDD, is a free public service. There is no cost to you. We can also get you a sign language interpreter for your medical appointments. This is provided at no cost to you. Call Member Services for more information.
- Use any hospital or other setting for emergency care

2.16 MEMBER RESPONSIBILITIES

All Health Choice Providers are expected to review and adhere to the Member Responsibilities as outlined below.

As a BCBSAZ Health Choice Member, you have the responsibility to:

- Protect your Member ID card at all times. Show your ID card before you get services. Do not throw your ID card away.
- Know the name of your primary care provider (PCP). This is your assigned provider. Tell him or her about your health history. Be sure to include any medical problems or concerns. This will help you get the best possible care.
- Follow your provider's instructions and treatment plan. This includes:
    - Taking all of your medicines as directed by your provider
    - Talking with your provider about your medical care
    - Understand, participate, and agree to your treatment plan with your provider
- Use the hospital emergency room for true emergencies only. Go to your provider or urgent care centers for all other care.
- Make your health care appointments during office hours whenever possible. Try to see your provider for routine care.
- Get to your appointments on time. Call your provider ahead of time if you cannot make your appointment. Arrive at the office early if you are seeing the provider for the first time.
- If you need a ride to your appointment, call 602-386-2447 at least three (3) days before your appointment.
- Bring records of your children's immunizations to every appointment. This includes all members who are 18 years of age or younger.
- Call the office at least one (1) day in advance if you cannot make your provider appointment. Remember to cancel your transportation.
- Tell AHCCCS if you have any changes to your personal information, such as address or family size.
- Tell BCBSAZ Health Choice or the AHCCCS Office of Inspector General (OIG) if you suspect fraud, waste, or abuse by a provider, member, or other person. To report fraud to OIG, call 602-417-4193.
- Tell AHCCCS if you get a new health insurance plan (primary insurance) or if you cancel a health insurance plan you were covered under when you enrolled in AHCCCS.
- Treat BCBSAZ Health Choice staff and providers with respect. Examples of appropriate and inappropriate behaviors include:
    - Appropriate behaviors:
        - Arriving to your scheduled appointment as directed by the provider's staff
        - Following the recommended steps to improve your health and wellness
        - Providing your provider with all of the relevant facts and not leaving out items that may impact your treatment plan i.e.: drug and alcohol use, other medications, living arrangements, etc.

- Inappropriate behaviors:
    - Not treating Health Plan or Provider staff with respect and dignity
    - Not showing to scheduled appointments
    - Using the Emergency Department for non-life-threatening care

2.17 RATE CODES

A complete list of rate codes can be found in the Codes & Values Manual at:
https://www.azahcccs.gov/Resources/Contractor/Manuals/TIG/HealthPlans/Codes/