Interpreter Services

For members who do not speak English or do not feel comfortable speaking it, Arkansas Total Care has a free service to help. This service is very important because you and your doctor must be able to talk about your medical or behavioral health concerns in a way you both can understand. Our interpreter services are provided at no cost to you and can help with many different languages. This includes sign language. We also have Spanish-speaking representatives available who can help you as needed. Arkansas Total Care members who are blind or visually impaired can call Customer Service for an oral interpretation. Video or Telephone Relay interpretation services should call Customer Service at 1-866-282-6280 (TDD/TTY: 711).

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Welcome & Resources

Welcome to Arkansas Total Care

Arkansas Total Care (ARTC) is your health plan. ARTC is a Managed Care Organization (MCO) contracted with the Arkansas Department of Human Services (DHS). You became an ARTC member because you:

- Live in Arkansas
- Currently receive Medicaid benefits
- Are eligible for the Medicaid program

The Medicaid program is the State of Arkansas' combined care model for providing Medicaid services. ARTC is contracted to coordinate healthcare for Medicaid beneficiaries. The administration of Medicaid is carried out by KDHE and KDADS.

ARTC is a health plan that gives you choices – from choosing your primary care provider (PCP), to participating in special programs that help you stay healthy.

Visit our website at **ArkansasTotalCare.com** for more information and services. The website also has a secure portal for members, like you, who want to keep track of their health coverage. Information regarding physician incentive plans is available upon request.

Member Handbook

The Member Handbook is a detailed guide to ARTC and your healthcare benefits. The Member Handbook explains your rights, your benefits, and your responsibilities as a member of Arkansas Total Care. Please read this booklet carefully and keep it. This booklet tells you how to access ARTC's healthcare services. It also gives you information about your ARTC benefits and services such as:

- What is covered by ARTC
- What is not covered by ARTC
- How to get the care you need
- How to get your prescriptions filled
- What you will have to pay for your healthcare or prescriptions
- What to do if you are unhappy about your health plan or coverage
- Eligibility requirements
- Materials you will receive from ARTC
- How to change your doctor on your ARTC ID card

Call Customer Service at 1-866-282-6280 (TDD/TTY: 711) to receive an additional copy of the Member Handbook at no charge. You may also visit our website at ArkansasTotalCare.com to view the Member Handbook online.

Provider Directory

ARTC has a Provider Directory that lists all of the providers and facilities in our network. The Provider Directory has information about our providers:

- Type or Specialty (such as PCPs)
- Address and Telephone number
- Office Hours
- Handicap-Accessibility of Sites/Facilities
- Languages Spoken (other than English)
- If they are accepting new patients
- Hospital Affiliations

1. Online – View our provider directory on our website – **ArkansasTotalCare.com**.
2. Call Customer Service at **1-866-282-6280 (TDD/TTY: 711)** to help you find a provider in your area or to get a free copy of our provider

directory. Customer Service can also give you information about the provider's medical school and residency.

ARTC Website

ArkansasTotalCare.com

ARTC's website helps you get answers. Our website has resources and features that make it easy for you to get quality care. It also gives you information on your ARTC benefits and services such as:

- Member Handbook
- Provider Directory
- Current news and events
- Online form submission
- Member self-service features such as Change PCP, view claims submitted on your behalf, and view care gaps
- ARTC programs and services
- CentAccount balances and usage

Member Advisory Committee

We need your help! Members can help ARTC with the way our health plan works. We have a Member Advisory Committee that gives members, like you, a chance to share your thoughts and ideas with us. At the meetings, you can give your thoughts and ideas on how services are provided.

The group meets up to four times a year. We may ask members, parents/foster parents, guardians of children who are members, member advocates and ARTC staff to join in the meeting. This gives you a chance to talk about your concerns with a variety of people and be a part of the solution. As a member you can:

- Have the opportunity to better understand why decisions are made and to ask questions;
- Understand how those changes will directly affect your family and others just like you;
- Share your experiences as an Arkansas Total Care member and tell us how we are doing;
- Be a part of the group that requests and respects member input.

For more information, or to join the Member Advisory Committee, call Customer Service at 1-866-282-6280 (TDD/TTY: 711).

Quality Improvement (QI)

ARTC is committed to providing quality healthcare for you. Our primary goal is to improve your health and help you manage any illness or disability. Our program is consistent with National Committee on Quality Assurance (NCQA) and Institute of Medicine (IOM) priorities. To help promote safe, reliable, and quality healthcare, our programs include:

- Conducting a thorough check on providers when they become part of the ARTC provider network
- Monitoring the access that ARTC members have to all types of healthcare services
- Providing programs and educational items about general healthcare and specific diseases
- Sending reminders to you to get annual tests, such as an adult physical, treatments like a flu shot, or prevention screenings for cervical, or breast cancer
- Investigating your concerns regarding the healthcare you have received. If you have a concern about the care you received from your doctor or any service provided by ARTC, please contact Customer Service at 1-866-282-6280 (TDD/TTY: 711)

ARTC believes that getting input from members, like you, can help make the services and quality of our programs better. We conduct a member survey each year that asks questions about your experience with

the healthcare and services you are receiving.

If you receive one of our member surveys, please be sure to fill out the survey and help us better serve you. If you would like a copy of our Quality Assessment and Performance Improvement (QAPI) plan, please contact us and we will provide one to you.

How to Contact Us:

Arkansas Total Care
8325 Lenexa Drive, Suite 200
Lenexa, KS 66214

Normal Business Hours of Operation 8:00 a.m. to 5:00 p.m. Central Standard Time

Customer Service 1-866-282-6280 (TDD/TTY: 711)

Dental/Vision/Pharmacy Services ..1-866-282-6280 (TDD/TTY: 711)

TDD/TTY line.....1-888-282-6428

Video Relay Services.....1-866-282-6280 (TDD/TTY: 711)

Customer Service Fax.....1-866-491-1824

Arkansas Relay Services
(voice and TTY) .....711 or 1-800-766-3777

Behavioral Health..1-866-282-6280 (TDD/TTY: 711)

OTHER IMPORTANT PHONE NUMBERS

Non-Emergency Transportation 1-877-917-8162

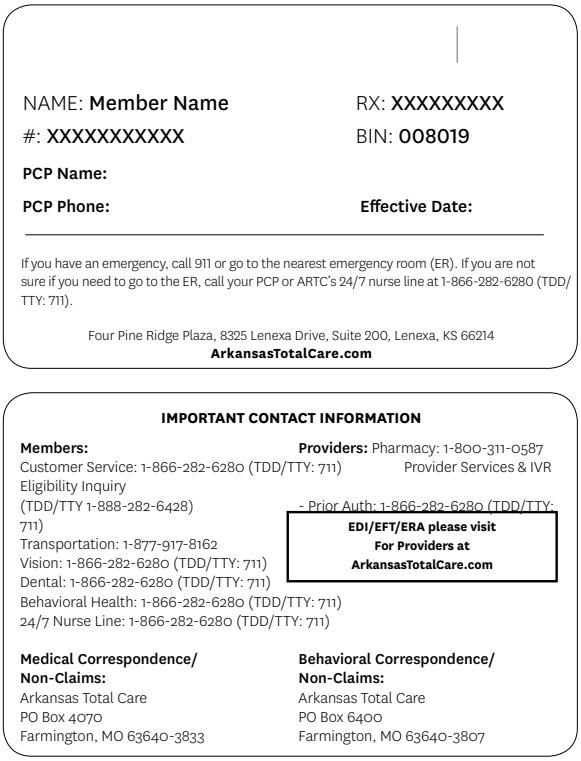
Nurse Advice Line for
24-Hour nurse advice .. 1-866-282-6280 (TDD/TTY: 711)

Emergency Services ..... Call 911

Your Member ID Card

When you enroll in ARTC, you will receive an ARTC Member ID Card within 10 business days of enrollment. This card is proof that you are enrolled with ARTC. You need to keep this card with you at all times. Please show this card every time you go for any service under the ARTC program. Your Arkansas Total Care ID card will show your name, Medicaid ID number, and Primary Care Provider (PCP) name and number. Please make sure the ID card lists the Primary Care Provider you are seeing. If you do not get your ARTC ID card within a few weeks after you join our plan or the name of your provider is not correct, please call Customer Service at 1-866-282-6280 (TDD/TTY: 711).

Here is an example of your Arkansas Total Care ID Card:



NAME: **Member Name**
#: **XXXXXXXXXXX**
RX: **XXXXXXXXX**
BIN: **008019**
PCP Name:
PCP Phone:
Effective Date:

If you have an emergency, call 911 or go to the nearest emergency room (ER). If you are not sure if you need to go to the ER, call your PCP or ARTC's 24/7 nurse line at 1-866-282-6280 (TDD/TTY: 711).

Four Pine Ridge Plaza, 8325 Lenexa Drive, Suite 200, Lenexa, KS 66214
ArkansasTotalCare.com

IMPORTANT CONTACT INFORMATION

Members:
Customer Service: 1-866-282-6280 (TDD/TTY: 711)
Eligibility Inquiry
(TDD/TTY 1-888-282-6428)
Transportation: 1-877-917-8162
Vision: 1-866-282-6280 (TDD/TTY: 711)
Dental: 1-866-282-6280 (TDD/TTY: 711)
Behavioral Health: 1-866-282-6280 (TDD/TTY: 711)
24/7 Nurse Line: 1-866-282-6280 (TDD/TTY: 711)

Providers: Pharmacy: 1-800-311-0587
Provider Services & IVR
- Prior Auth: 1-866-282-6280 (TDD/TTY: 711)

EDI/EFT/ERA please visit
For Providers at
ArkansasTotalCare.com

Medical Correspondence/ Non-Claims:
Arkansas Total Care
PO Box 4070
Farmington, MO 63640-3833

Behavioral Correspondence/ Non-Claims:
Arkansas Total Care
PO Box 6400
Farmington, MO 63640-3807

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How Your Plan Works

Customer Service

Our Member Services will tell you how ARTC works. They will also tell you how to get the care you need. Customer Service can help you do the following:

- Find a Primary Care Provider (PCP)
- Schedule an appointment with your PCP
- Schedule appointments to see a dentist or eye doctor
- Get a new ID card
- Get information about covered and non-covered benefits
- File Grievances and Appeals
- Get Interpretation Services
- Get information about your health
- Find a doctor or specialist in our network
- Report a potential fraud issue
- Get a copy of member materials
- Get a copy of member materials in another language or format
- Get information about case management

Please call 1-866-282-6280 (TDD/TTY: 711) (TDD/TTY 1- 888-282-6428). We are open Monday through Friday from 8:00 a.m. to 5:00 p.m. CST. Calls received after business hours or on holidays are answered by our Nurse Advice Line.

Nurse Advice Line

This Nurse Advice Line is a free health information phone line that is ready to answer your health questions 24 hours a day – every day of the year. The registered nurses answering the calls have spent a lot of time caring for people, and are ready and eager to help you.

The services listed below are available by calling 1-866-282-6280 (TDD/TTY: 711).

- Medical advice
- Health information library
- Answers to questions about your health
- Advice about a sick child
- Help with scheduling PCP appointments
- Receive translation services

Sometimes you may not be sure if you need to go to the emergency room (ER). Call the Nurse Advice Line. They can help you decide where to go for care. If you have an emergency, call 911 or go to the nearest ER.

Membership and Eligibility Information

ELIGIBILITY

To be a member of our health plan, you must be eligible for the Medicaid program. Eligibility is determined by the State of Arkansas, not by Arkansas Total Care.

If you have questions about your eligibility, you may call the Medicaid Clearinghouse at 1-800-792-4884.

Major Life Changes

Life changes might affect your eligibility with the State. If you have a major change in your life, please contact the Medicaid Clearinghouse at 1-800-792-4884 within 10 days. It is important to report these changes. You should also contact Customer Service at 1-866-282-6280 (TDD/TTY: 711).

Some examples of major life changes are:

- A change in your name
- Move to a different address
- A change in your job/income
- Change in family size
- A change in blindness or disability
- Pregnancy
- Moving to a new county or out of state

Enrollment

OPEN ENROLLMENT

You will have an annual enrollment period for the Medicaid program. The State of Arkansas will send you information when it is time to renew your enrollment in Medicaid. During this period, you may choose another health plan for any reason. For questions about changing your health plan, please contact the Medicaid Enrollment Center at 1-866-305-5147.

DISENROLLMENT

You may request to disenroll from ARTC with or without cause by contacting the Enrollment Center at 1-866-305-5147. ARTC will not directly disenroll any member if your disenrollment is not provided on the state Enrollment file. Medicaid program procedures must be followed for all disenrollment requests. A member's request for disenrollment must be directed to Medicaid either orally or in writing. We will ensure
your right to disenroll is not restricted in any way.

You may request disenrollment **without cause** at the following times:

- During your initial ninety (90) day enrollment period
- During your annual open enrollment period announced by the State

You may request disenrollment with cause at any time. A determination will be made by the State, which has the authority and discretion to disenroll members for the following:

- If you need related services to be performed at the same time and not all related services are available within the network and your PCP or another provider determines receiving the services separately would subject you to unnecessary risk
- Poor quality of care, lack of access to services covered under the plan, or lack of access to providers experienced in dealing with the member's healthcare needs
- Transfer to a Medical eligibility category not included in benefits
- Member no longer resides in the State of Arkansas
- Member no longer qualifies for medical assistance under one of the Medicaid eligibility categories in the targeted population
- If ARTC does not, because of moral or religious objections, cover the service you are seeking

NEWBORN ENROLLMENT

If you are an ARTC member and give birth, you must contact the Medicaid Clearinghouse at 1-800-792-4884 as soon as possible to report the birth of your child. Your baby will be automatically enrolled with ARTC once benefits are approved by Medicaid. Please contact Customer Service at 1-866-282-6280 (TDD/TTY: 711) if you need any help.

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Benefits

Covered Services

This section describes your ARTC covered benefits and benefit limits. With ARTC, you are entitled to receive medical services and the benefits listed in this section. You are responsible for any non-covered services. Covered benefits are listed below. **Please Note:**

- ARTC will not limit or deny services because of a condition you already have.
- For services which are medically necessary and covered by ARTC, you will not have any co-payments (co-pays), deductibles, or other cost sharing that requires you to pay a portion of the fee – except as noted in the Member Responsibilities section.
- If you receive healthcare services which are not medically necessary or if you receive care from doctors who are out of the ARTC network, you may be responsible for payment. If you have questions about medical necessity or which doctors are in your network, call Customer Service at 1-866-282-6280 (TDD/TTY: 711).

Benefits Grid

This list does not intend to be an all-inclusive list of covered and non-covered benefits. All services are subject to benefit coverage, limitations, and exclusions, some of which are described below.

Covered benefits or services are provided by ARTC if the member meets certain criteria, called medical necessity. Covered benefits may be denied if the member's situation or health condition does not show a need for the service.

Some services require prior authorization. ARTC members are not responsible for any cost sharing for covered services, except as noted in the Member Responsibilities section.

BENEFITS	COVERAGE	LIMITED BENEFIT	COMMENTS
Alternative Medicine	Not Covered		Acupuncture, Christian science, faith healing, herbal therapy, homeopathy, massage, massage therapy or naturopathy.
Abortions	Not Covered	Only covered when a member suffers from a rape, incest, or life of mother is threatened.	Abortion necessity form required at the time the claim is submitted.
All services are subject to benefit coverage, limitations, and exclusions, some of which are described here. Call Customer Service at 1-866-282-6280 (TDD/TTY: 711) to get more information on benefit coverage.			

BENEFITS	COVERAGE	LIMITED BENEFIT	COMMENTS
Adult Care Home Services	Covered		
Allergy Services (when billed with office visit)	Covered		
Ambulance (Emergency Transportation)	Covered	Ground, rotary and fixed wing	
Ambulatory Surgery Center	Covered		
Anesthesia Services	Covered		
Audiology Services	Covered		
Bariatric Surgery	Covered		
B-12 Injections	Covered		
Behavioral Health Services	Covered		
Birthing Centers	Covered		
Cardiac Rehabilitation	Covered		
Chemical Dependency Treatment	Covered		
Chemotherapy	Covered		
Chiropractor Services	Not Covered		Only covered if member has Medicare coverage in a Qualified Medicare Beneficiary program plan.
Circumcisions (Routine/ Elective)	Covered		
Cosmetic or Plastic Surgery	Not Covered		Examples are tattoo removal, face lifts, ear or body piercing and hair transplants. Any medically necessary procedures that could be considered cosmetic in nature must be prior authorized.
Dental Services	Covered	For members under 21, benefits vary by age (See **Value-Added Benefits** table below for coverage for adults)	
Developmental Testing	Covered	1 per day, up to 3 visits per calendar year	
All services are subject to benefit coverage, limitations, and exclusions, some of which are described here. Call Customer Service at 1-866-282-6280 (TDD/TTY: 711) to get more information on benefit coverage.			

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BENEFITS	COVERAGE	LIMITED BENEFIT	COMMENTS
Diabetic Education	Not Covered		Provided by the Healthy Solutions for Life program
Diagnosis and Treatment of Infertility, Impotence and Sexual Dysfunction	Not Covered		
Dialysis	Covered		
Dietitian Services	Covered	Services limited to members age 20 and under.	
Durable Medical Equipment	Covered		
Early Periodic Screening Diagnosis and Treatment Services	Covered	Members under 21 years old	
Emergency Room Services	Covered		
Experimental Procedures, Drugs and Equipment	Not Covered		
Family Planning	Covered		
Fluoride Application	Covered	Limited to 3 per calendar year for children under 21 meeting EPSDT criteria.	
Gender Reassignment Surgery	Not Covered		
Hearing Aids	Covered	Some limitations apply for ages over 20.	Batteries are limited to 6 per month for monaural hearing aids and 12 per month for binaural hearing aids. Hearing aids are covered 1 every 4 years.
Hearing Aid Repairs	Covered	Charges for hearing aid repairs under $15 are not covered.	
Hearing Aids (Bone Anchored)	Covered	Limited to members 5 to 20 years of age.	
HIV Testing and Counseling	Covered		
Home Births	Covered	Doula services are not covered.	
Home Health Care Services	Covered		
Hospice Care	Covered		
All services are subject to benefit coverage, limitations, and exclusions, some of which are described here. Call Customer Service at 1-866-282-6280 (TDD/TTY: 711) to get more information on benefit coverage.			

BENEFITS	COVERAGE	LIMITED BENEFIT	COMMENTS
Hospital Services: Inpatient	Covered		
Hospital Services: Outpatient	Covered		
Hyperbaric Oxygen Therapy	Covered		
Hysterectomy	Covered	Not covered if only to prevent pregnancy.	Sterilization consent form is required with claim submission by your doctor.
Laboratory Services–Outpatient	Covered		
Laboratory Services–Inpatient	Covered		
Maternity (OB Routine Ultrasounds)	Covered	Two routine OB sonograms covered per fetus per pregnancy.	
Maternity Care Services	Covered		Examples are: · Nurse midwife services · Pregnancy related services · Care for conditions that might complicate pregnancy
Medical Nutrition (through stomach or veins)	Covered	Some limitations apply.	
Non-Emergency Medical Transportation–(Ambulance)	Covered		Examples are transportation for non-ambulatory patients, patient home to hospital or hospital to patient's home, transfers between hospitals. Prior authorization required for fixed-wing transportation.
Non-Emergency Medical (NEMT)	Covered		For transportation call: 1-877-917-8162
Non-Medical Equipment	Not Covered		
Nursing Facility	Covered		
Outpatient Hospital/ Outpatient Surgery	Covered		
All services are subject to benefit coverage, limitations, and exclusions, some of which are described here. Call Customer Service at 1-866-282-6280 (TDD/TTY: 711) to get more information on benefit coverage.			

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BENEFITS	COVERAGE	LIMITED BENEFIT	COMMENTS
Oxygen and Respiratory Services	Covered	Some limitations apply.	
Pain Management	Covered		
Personal Comfort Items	Not Covered		
Physician and Nurse Practitioner Services	Covered		
Physical Exam Required for Insurance or Licensing	Not Covered		
Physical, Occupational and Speech Therapy	Covered		
Podiatrist Services	Covered	For members age 20 and under.	For EPSDT additional visits may be provided with prior authorization.
Prescription Drugs	Covered		
Preventive Care	Covered	Certain limitations may apply.	
Prosthetic and Orthotic Devices	Covered		
Psychotherapy	Covered		
Psychological Testing	Covered		
Radial Keratotomy	Not Covered		
Radiology and X-rays	Covered		
Radiology (High Tech Imaging)	Covered	Includes CT, MRI and MRA. PET scans are not covered.	
Reconstructive Surgery after Mastectomy	Covered	Related to diagnosis of breast cancer only.	
School-Based Services	Not Covered		School-Based Services are covered through the State's Fee-for-Service program.
School or Employment Physicals	Covered		Provider must bill using the appropriate evaluation and management code.
Screening and Treatment for STD	Covered		
Services not allowed by federal or state law	Not Covered		
All services are subject to benefit coverage, limitations, and exclusions, some of which are described here. Call Customer Service at 1-866-282-6280 (TDD/TTY: 711) to get more information on benefit coverage.			

BENEFITS	COVERAGE	LIMITED BENEFIT	COMMENTS
Sleep Studies	Covered	For members age 20 and under or as part of the preoperative work-up for bariatric surgery.	
Transplant Service	Covered	Covered for certain organs. Limitations apply. Confirm with the plan during prior authorization or by calling customer service.	Members needing a kidney transplant for end-stage renal disease should apply for Medicare prior to transplant. Provide denial information if asking the plan to cover as primary payor.
Transportation - See Non-Emergency Medical Transportation	Covered		
Urgent Care Services	Covered		
Vision & Eye Exams	Covered	One complete eye exam and one pair of glasses are covered for members 21 years and older each year. Eyeglasses, repairs and exams as needed for members under 21, up to 3 pairs per calendar year.	For coverage questions, call Envolve Vision. 1-866-282-6280 (TDD/TTY: 711)
All services are subject to benefit coverage, limitations, and exclusions, some of which are described here. Call Customer Service at 1-866-282-6280 (TDD/TTY: 711) to get more information on benefit coverage.			

New Technology

ARTC evaluates new technology and new uses of technology for possible inclusion as covered services. Our Medical Director and Medical Management team identify procedures or devices for review. If a new technology has not yet been reviewed by the team, your provider can request a determination for approval by calling our Provider Services department.

Home and Community Based Services (HCBS)

Home and Community Based Service programs provide additional services to persons with disabilities to allow them to live in the community and take an active role in their care. The specific waiver services available for each waiver program are listed below. Eligibility is determined by entities the State contracts with such as ADRCs, CDDOs and CMHCs. ARTC will provide care management (CM) and coordinate access to covered benefits and available community resources.

HCBS – Autism

- Family Adjustment Counseling
- Parent Support & Training
- Respite

HCBS – Frail Elderly (FE)

- Adult Day Care
- Assistive Services (Lifetime maximum of $7,500)
- Personal Care Services (self-directed or agency-directed)
- Comprehensive Support
- Home Telehealth (remote monitoring system)
- Medication Reminder
- Nurse Evaluation Visit
- Oral Health Services
- Personal Emergency Response System (PERS) and installation
- Enhanced Care Services
- Wellness Monitoring
- Financial Management Services

HCBS – Physical Disabilities (PD)

- Assistive Services
- Home-Delivered Meals Service
- Medication Reminder Services (Call, dispenser, and dispenser installation)
- Personal Emergency Response System (PERS) and installation
- Personal care services (self-directed or agency-directed)
- Enhanced Care Services
- Financial Management Services

HCBS – Traumatic Brain Injury (TBI)

- Home-Delivered Meals Service
- Assistive Services
- Personal Emergency Response System (PERS) and installation
- Personal Care Services (self-directed or agency-directed)
- Rehabilitation Therapies: Physical Therapy / Occupational Therapy / Speech Therapy; Cognitive Rehabilitation and Behavior Therapy
- Enhanced Care Services
- Transitional Living Skills
- Medication Reminder
- Financial Management Services

HCBS – Technology Assisted (TA)

- Health Maintenance Monitoring (HMM)
- Home Modification/Assistive Services
- Personal Care Services
- Medical Respite
- Specialized Medical Care (SMC)
- Financial Management Services

HCBS – Severe Emotional Disturbance (SED)

- Attendant Care
- Wraparound Facilitation
- Independent Living/Skills Building
- Short Term Respite Care
- Parent Support and Training
- Professional Resource Family Care

HCBS – Intellectual/Developmental Disability (I/DD)

- Home Modification/Assistive Services
- Day Services
- Personal Emergency Response Service (PERS) and rental
- Overnight Respite
- Personal Care Services (agency and self-directed)
- Financial Management Services
- Residential Services
- Enhanced Care Services
- Specialized Medical Care
- Supported Employment
- Targeted Case Management
- Wellness Monitoring

MONEY FOLLOWS THE PERSON SERVICES

Money Follows the Person (MFP) is a federal demonstration grant given to help residents of qualified institutional settings move back into their communities to live. Members who were eligible for

and received Money Follows the Person services will continue to receive these services for 365 days from the date of eligibility. If you have questions, please contact your care manager.

Financial Management Services (FMS)

In accordance with the state of Arkansas law (K.S.A. 39-7100) and the self-direction model and within the scope of the vendor-fiscal model, Arkansas Total Care members who are receiving HCBS have the option to self-direct some or all of their services. The self-direction model allows the Arkansas Total Care member to make a decision about, direct the provisions of and control the personal care services received by the member, including but not limited to selecting, training, managing, paying and dismissing of a direct support worker. An Arkansas Total Care member or the members' representative has authority over selected services and can accept direct responsibility for these services with the assistance of a FMS provider.

FMS Rights and Responsibilities

When an ARTC member or the member's representative chooses an FMS provider, he or she must be fully informed by the FMS provider of his or her rights and responsibilities to:

- Choose and direct support services
- Choose and direct the workers who provide the services
- Perform the roles and responsibilities as employer
- Understand the roles and responsibilities of the FMS provider
- Receive initial and ongoing skills training as requested

Once fully informed, the ARTC member or the member's representative must negotiate, review, and sign a FMS Service Agreement with the FMS provider. ARTC also has educational materials about self-direction available for our members.

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ARTC Value-added Services

Dental Visits	For adults 21 and older - one dental checkup every six months.
CentAccount Rewards	Members can earn rewards on our CentAccount card when they get health checkups and screenings. Members can earn $5-$50 or more in CentAccount rewards.
SafeLink® and ConnectionsPlus Phones	SafeLink® and ConnectionsPlus Phones provide a free cell phone to members. SafeLink® provides up to 250 free minutes of service per month with unlimited texting and free calls to and from Arkansas Total Care. Members will have telephone access to their health care providers.
Start Smart® for Your Baby	This program gives support, education and gifts for moms, babies, and families. The program includes the services below. There is no cost to the member. • In-home help with healthcare and social service benefits. • Group baby showers for pregnant mothers. Members are given diapers and other health items. • Start Smart birthday programs for children.
Community Programs for Healthy Children	ARTC offers free services to promote healthy lifestyles for kids, such as membership fees to Boys & Girls Clubs and the Adopt-A-School Program.
Care Attendant	We provide members on the I/DD waiting list with a care attendant for medical appointments if needed.
Practice Dental Visits	We also provide practice visits to dentists for members with developmental disabilities and children on the autism waiver to help them become more comfortable with this preventive care visit.
Smoking Cessation	Members can participate in a smoking cessation program offered through Healthy Solutions for Life. (Nicotine replacement therapy is a regular benefit when prescribed by the doctor.)
In-home Tele-Health	In-home Tele-health is available for adults. This service helps members stay at home when they need help to manage their chronic conditions.
MyStrength Program	Our MyStrength online program offers eLearning to help members overcome depression and anxiety with simple tools, weekly exercises, mood trackers and daily inspirational quotes and videos in a safe and confidential environment. The program may be used independently or in conjunction with other care.
Farmers' Market Vouchers	We promote healthy eating. Members can receive $10 farmers' market vouchers at special events with participating farmers' markets.
Medication Review	A comprehensive medication review with a local pharmacist is available to eligible members. The review includes a 30 minute face-to-face consultation with a local pharmacist.
Caregiver Respite	We provide additional respite for caregivers. We provide up to 16 hours per year of respite for caregivers of persons on the I/DD waiting list, those who receive F/E waiver services and children adopted from foster care. Members may contact their ARTC care manager to access this service.

Hospital Companionship	We also provide up to 16 hours of hospital companionship for persons on the I/DD and F/E waivers. Members may contact their ARTC care manager to access this service.
Incontinence Supplies	Eligible members on the F/E waiver receive up to $100 per year for incontinence supplies.
Choose Health Program	Our Choose Health Program targets members with chronic health conditions to determine how emotions can impact their condition (i.e. stress, poor sleep, changes in appetite). As a part of the program, participants are assigned a Choose Health Coach who works with the entire health care team to ensure members have everything they need to feel their best.
Healthy Solutions for Life	We provide targeted disease management under the Healthy Solutions for Life Program to members with the following conditions: • asthma (adults and children); • COPD (adults); • diabetes (adults and children); • heart disease (CAD) (adults); • hypertension (adults); • obesity (adults); (Members may be referred by their physician, referred by the health plan, or self-enrolled in any of these programs). **Adults are classified as 18 years and older. Notable differences with the Healthy Solutions for Life program is: • These are opt in programs – the member must consent. • We use motivational behavior techniques. • No time limit for the programs. Enrollment duration is based on the member's progress. - All asthma members receive a peak flow meter and spacer as part of enrollment in the asthma program. Children under 5 receive a mask also.

Member Responsibility

WHEN YOU HAVE TO PAY AND WHEN YOU DON'T

ARTC will cover most of your medical bills, but there are times when services are not covered or services are limited. You should not receive a bill if the medical service you got is a covered ARTC benefit. You will be responsible for all non-covered services. Information about covered and non-covered services are in this handbook and on the ARTC website. Members should follow the guidelines below:

- **Always** ask if the service is covered before you receive it.
- If you want to know if a specific procedure code or pharmacy item is covered, call Customer Service at 1-866-282-6280 (TDD/TTY: 711).
- If you receive a non-covered service, your provider may ask you to sign a statement that you will pay for the services.
- You must use a provider who accepts your ARTC ID Card. If you are an ARTC member, you must use a provider in the Arkansas Total Care network. If you don't, you may have to pay the bill.

- Show your ARTC ID card and other cards at the time you get the service or item. If you don't, you may be responsible for the bill.
- If your provider recommends you get a service that is not covered, you must pay for that service if you choose to get it.
- If you request a service that is not covered, you must pay for that service.

You will not have to pay for covered health care services even if:

- The State does not pay Arkansas Total Care.
- Arkansas Total Care does not pay your provider.
- Your provider's bill is more than Arkansas Total Care will pay.
- Arkansas Total Care cannot pay its bills.

SPENDDOWN

The Medically Needy program offers coverage to people who have income over the maximum allowable income standard. The spenddown amount is your share of your family's medical bills. The spenddown amount is like an insurance deductible. If you have a spenddown amount (deductible), you are responsible for that amount. We will consider paying for any Medicaid-covered services that go over your spenddown amount.

MEDICALLY NEEDY COVERAGE

A spenddown can be set up for you if you are in any one or more of the following groups:

- Pregnant Women
- Children under the age of 19
- Seniors age 65 and over
- Persons determined disabled by Social Security

PATIENT LIABILITY & CLIENT OBLIGATION

Patient Liability is a fixed monthly amount determined by the state for members who are in a long term care facility. This amount is the member's responsibility and is assigned to a specific provider or providers.

Client obligation is a fixed monthly amount determined by the state for members in HCBS services. This amount is the member's responsibility to pay and is assigned to one or more providers for payment. The member pays the amount owed to the provider assigned. The member can find which provider is assigned by looking at their Integrated Service Plan (ISP). This amount is the member's responsibility and is assigned to a specific provider or providers.

These are mutually exclusive amounts, meaning a member will not have both Patient Liability and Client Obligation. A member could have one or the other but never both.

For more information, please contact Customer Service at 1-866-282-6280 (TDD/TTY: 711).

How to Obtain Healthcare

Three Easy Steps to Establish a PCP Relationship

1. **Choose a doctor.** If you do not choose one, ARTC will choose one for you. You can find this information on your member ID card. You will be able to switch to a different doctor during our new member welcome call or you can call Customer Service 1-866-282-6280 (TDD/TTY: 711). Be sure to have your PCP's name on your ID card.
   If you have Medicare a PCP will not be listed on your ID card
   If a member is in Foster Care a PCP will not be listed on the ID card
2. **Make an appointment with your doctor if you have not seen one in the last 12 months.**
3. **Talk to your doctor about any health problems you are having.**

Primary Care Provider (PCP)

WHAT IS A PCP?

When you enroll in ARTC, you must choose a PCP. Your primary care provider, or PCP, is a doctor you see on a regular basis to take care of your medical needs. Make an appointment with your PCP in the first 90 days of becoming a member, even if you are not sick. You should receive all of your basic medical care from your PCP. You can call your PCP when you are sick and do not know what to do. Seeing your doctor for regular check-ups helps you find health problems early. This can help prevent going to the emergency room.

If you have never seen your PCP, as soon as you join ARTC you should call your PCP. Introduce yourself as a new member. Make an appointment in the first 90 days for a preventive visit. It is best to not wait until you are sick to meet your doctor for the first time. Be sure the doctor name on your ARTC ID card is the doctor you are seeing for your check-ups.

PCP RESPONSIBILITIES

Your PCP will:

- Make sure that you get all medically necessary services in a timely manner.
- Follow-up on the care you get from other medical providers.
- Take care of referrals for specialty care and services offered.
- Provide any ongoing care you need.
- Update your medical record, including keeping track of all the care that you get with your PCP and specialists.
- Provide services in the same manner for all patients.
- Give you regular physical exams.
- Provide preventive care.
- Give you regular immunizations.
- Make sure you can contact him/her or another doctor at all times.
- Discuss what advance directives are and file the advance directives appropriately in your medical record.

ARTC believes that seeing your PCP is important. We offer a program called the CentAccount® program. You can earn rewards for healthy behaviors, like visiting your PCP. CentAccount® gives you rewards

for healthy activities. The rewards are used at stores to purchase items for you and your family. Find the CentAccount® section in this handbook for details about earning healthy rewards.

CHOOSING YOUR PCP

ARTC lists all providers in the network on the Arkansas Total Care website at ArkansasTotalCare.com. On *Find A Provider* you will see a list of doctors and hospitals. You will also see the doctor's contact information and their specialty. Our Provider Directory will show the addresses, phone numbers, and any languages the provider may speak. Be sure the PCP name on your ARTC ID card is the doctor you are seeing for your check-ups. When picking a PCP, look for one of the following kinds of providers.

- Family Practitioner
- General Practitioner
- Internal Medicine
- Nurse Practitioner
- Obstetrician/Gynecologist (OB/GYN)
- Physician Assistants

Specialists can be your PCP for special needs, upon request. ARTC is always working to have the best provider network for all of its members. New doctors are added daily, so check the ARTC website at ArkansasTotalCare.com to see if new providers have been added. If you would like a free copy of our provider directory or want to know more about the PCP before you choose, please call Customer Service at 1-866-282-6280 (TDD/TTY: 711). Women have direct access to women's health specialists in addition to their PCP if their PCP is not a women's health specialist.

CHANGING YOUR PCP

You may change your PCP at any time if:

- Your PCP is no longer in your area
- You are not satisfied with your PCP's services
- The PCP does not provide the services you seek because of religious or moral reasons
- You want the same PCP as other family members

You must notify us when you change your PCP. If the PCP listed on your ARTC ID card is not the doctor you see, please call Customer Service at 1-866-282-6280 (TDD/TTY: 711) or online at ArkansasTotalCare.com.

MAKING AN APPOINTMENT WITH YOUR PCP

Once you have selected a PCP, make an appointment to meet with your doctor annually or within 90 days if you have not been to the doctor within the last year. This will give you and your doctor a chance to get to know each other. Your doctor can give you medical care, advice, and information about your health.

Call your PCP's office to make an appointment. Remember to take your member ID card with you every time you go to the doctor's office. Call ARTC if the PCP name on your ID card is not the doctor you see for your check-ups. **If you have difficulty getting an appointment to see your doctor, please call Customer Service at 1-866-282-6280 (TDD/TTY: 711).**

After Hours Appointments with Your PCP
You can call your PCP's office for information on receiving after hours care in your area. If you have a medical problem or question and cannot reach your PCP during normal office hours, you can call Customer Service or Nurse Advice Line at 1-866-282-6280 (TDD/TTY: 711). Nurse Advice Line is ARTC's 24-hour medical nurse line. You will speak to a nurse. If you have an emergency, call 911 or go to the nearest ER.

NOTE: Except for emergency & family planning, all services must be obtained through ARTC network providers or pre-approved out-of-network providers.

IMPORTANT: If you cannot keep an appointment, please call the doctor's office as a courtesy to cancel

at least 24-hours in advance. If you need to change an appointment, call the doctor's office as soon as possible. They can make a new appointment for you. If you need help getting an appointment, call Customer Service at 1-866-282-6280 (TDD/TTY: 711). If you arranged transportation for an appointment that you cannot keep, also cancel your transportation by calling 1-877-917-8162.

Appointment Availability and Wait Times

Your health care providers must see you within 3 weeks when you call for a regular health care, mental health, vision, lab or x-ray appointment.

Sometimes you need medical care soon, but it is not an emergency. This is called urgent care. Your health care provider must have appointments within 48 hours when you need urgent care.

A provider may send you to see someone else when they are not able to see you that soon. If you see a new provider, remember to take your insurance cards with you.

Your time in the provider's waiting room should not be longer than 45 minutes.

Please call Customer Service at 1-866-282-6280 (TDD/TTY: 711) if you need help making an appointment or if you experience long wait times in a provider's office.

PCP APPOINTMENTS.

- Regular: members are seen within 3 weeks.
- Urgent: members are seen within 48 hours.

SUBSTANCE USE DISORDER (SUD) APPOINTMENTS.

- Regular: members are assessed within 14 days, and treatment services are delivered within 14 days after assessment.
- Urgent: members are assessed within 24 hours, and services are delivered within 48 hours.
- Emergency: members are seen immediately.
- IV Drug Users: members are seen within 14 days.
- Pregnant IV Drug Users: members are assessed within 24 hours of request/referral to treatment and treated within 48 hours of an assessment.

MENTAL HEALTH APPOINTMENTS.

- Regular: members must be referred within 5 days; assessed and/or treated within 9 working days from referral or 10 working days from previous treatment.
- Urgent: members must be referred within 24 hours; assessed and/or treated within 48 hours from referral for outpatient mental health services, and within 24 hours from referral for an urgent concurrent utilization review screen.
- Emergency: members are referred immediately; assessed and/or treated within 3 hours for an outpatient mental health service, and within 1 hour from referral for an emergent concurrent utilization review screen.
- Planned Inpatient Psychiatric: members are referred within 48 hours; assessed and treated within 5 working days from referral.
- Pregnant Women: members are treated within 24 hours of an assessment.

SPECIALISTS AND URGENT CARE APPOINTMENTS.

- Regular: members are seen within 30 days.
- Urgent: members are seen within 48 hours.

VISION APPOINTMENTS.

- Regular: members are seen within 3 weeks.
- Urgent: members are seen within 48 hours.

LAB AND X-RAY SERVICES.

- Regular: members are seen within 3 weeks.
- Urgent: members are seen within 48 hours.

What to Do if Your Provider Leaves the ARTC Network

If your PCP is planning to leave the ARTC provider network, we will send you a notice before the date this occurs, or as soon as we are notified. We will automatically reassign you to another PCP so you always have access to the care you need. We will send you a new member ID card identifying your new PCP. If you want a different PCP, please call Customer Service at 1-866-282-6280 (TDD/TTY: 711). You can change your PCP at any time.

ARTC may approve visits with your doctor for up to 90 days after he/she leaves the network. We can do this if you are in active treatment with your doctor. Members in the second or third trimester of pregnancy can keep the same doctor until after the first post-partum visit. During this time, we will help you find a new doctor. You will receive the same covered services. The doctor must agree to:

- Treat you for your healthcare needs.
- Accept the same payment rate from ARTC.
- Follow ARTC's quality assurance standards.
- Follow ARTC's policies about prior authorization and using a treatment plan.
- Provide necessary medical information to you related to your care.

Continued coverage is only available if your PCP or specialist was not terminated by ARTC due to quality of care.

Continuing Services with Out-of-Network Providers

Sometimes new members are getting care from a doctor that is not in ARTC's provider network. In some cases, you may be allowed to continue care with your doctor for up to 90 days. In order to have your previous doctor's services continue, they must be prior authorized by ARTC. If you have questions, call Customer Service at 1-866-282-6280 (TDD/TTY: 711).

New members in the second or third trimester of pregnancy can keep the same doctor until you have had your baby and completed your first post-partum visit. If you are a member who is terminally ill, you may continue to see your doctor for your care. In order to have your previous doctor's services continue, they must be prior authorized by ARTC. If you have questions, call Customer Service at 1-866-282-6280 (TDD/TTY: 711).

Medical Services

Medically Necessary Services

Covered services that you receive must be medically necessary. This means getting the right care, at the right place, at the right time. ARTC uses standard guidelines to check medical necessity. ARTC does not reward its network providers or their staff to deny care.

Prior Authorization for Services

When you need care, always start with a call to your PCP. Some covered services may require prior authorization or review by ARTC before services are provided. This includes services or visits to an out-of-network provider and some specialists. Home health services and some surgeries also need to be reviewed. Your doctor can tell you if a service needs to be reviewed. The list can be found on ARTC's website at ArkansasTotalCare.com. You can also call Customer Service at 1-866-282-6280 (TDD/TTY: 711) to see if something needs to be reviewed by us.

Your doctor will give us information about why you need the service. ARTC will look to see if the service is covered and that it is appropriate. ARTC will make the decision as soon as possible, based on your medical condition. Standard decisions are made within 14 days. An extension of this timeline may occur if the enrollee or provider requests an extension, or if ARTC justifies (to the State agency upon request) a need for additional information to make an educated decision. Extensions will be in the enrollee's interest. ARTC will let you and your doctor know if the service is approved or denied in writing. Sometimes, ARTC may need more time to make a decision on a prior authorization when it is in the member's best interest.

If the service is urgent, the decision will be made within three days.

For these urgent requests, ARTC will make a reasonable attempt to call your provider with the decision. If you or your doctor is not happy with the decision you can ask for a second review. This is called an appeal. See the "Member Satisfaction" section in your Member Handbook for more information about appeals.

If there are any major changes to the prior authorization process, we will let you and your doctors know right away.

Second Medical Opinion

You have the right to a second opinion about your treatment choice. This means talking to a different doctor about an issue to see what they have to say. The second doctor is able to give you their point of view. This may help you decide if certain services or methods are best for you. If you want a second opinion, tell your PCP.

Customer Service, or your PCP, can help you find a doctor to give you a second opinion. You may choose any ARTC network provider. If you are unable to find a doctor in the ARTC network, we will help you find a doctor outside the network. If you need to see an out-of-network provider for the second opinion, it must be prior approved by ARTC.

Any tests that are ordered for a second opinion

should be given by a doctor in the ARTC network. Tests requested by the doctor giving you a second opinion must be prior approved by ARTC. Your PCP will look at the second opinion and help you decide on the best treatment plan.

How to Get Medical Care When You Are Out of State

If you are out of the area and have an emergency, **call 911 or go to the nearest ER**. Be sure to call us and report your emergency **within 48 hours**. You do not need prior approval. ARTC will cover only medically necessary emergency services out of state.

If you are out of state and have an **urgent problem,** go to an urgent care clinic or you may go to a PCP. Be sure to show your ARTC ID card prior to receiving services. Follow-up care after out-of-state services should be made with the member's in-network PCP.

Your PCP will help you get the post-stabilzation care, or follow up care, you need after an emergency. You may receive this follow up care whether or not the doctor is in the ARTC provider network to be sure your condition is stable.

The two situations where you are covered for services out of state are as follows:

- You are out of state and you have a medical or behavioral health emergency. You can go to an ER in any state if you have a true medical or behavioral health emergency. If you are seen at an out-of-state hospital for an emergency, your follow up care must be with an ARTC network provider. You may also need to contact your PCP to get a referral if you need to see a specialist.
- It is determined that you need special care that you cannot receive in Arkansas. If ARTC approves, the cost of the care you get in the other state will be covered. Members are not covered for any services outside of the United States.

Out-of-Network Care

Out-of-network emergency services do not need approval from ARTC. All other covered services from an out-of-network provider need prior authorization by ARTC. We will first check to see if there is a network provider that can treat your medical condition. If there is not, we will help you find an out-of-network provider. You will be financially responsible for payment of the out of network service(s) if ARTC did not approve the visit or service. If you have questions, call Customer Service at 1-866-282-6280 (TDD/TTY: 711). ARTC will notify you when the referral is approved.

Referrals to Specialty Care

You may need to see a certain doctor for specific medical problems, conditions, injuries, and/or diseases. Talk to your PCP first. Your PCP will refer you to a specialist. A specialist is a doctor who works in one healthcare area; for example, a doctor who only works with the heart, skin, or bones. Normally, an ARTC doctor will refer you to another ARTC doctor who is a specialist, unless your medical condition could be better treated by someone other than an ARTC doctor. ARTC will not pay for an out-of-network specialist visit unless your doctor and ARTC approves the visit. If you have questions about getting a referral, call Customer Service at 1-866-282-6280 (TDD/TTY: 711).

Some conditions may need ongoing care from a specialist. ARTC will allow your PCP to give a standing referral to a specialist in the ARTC network when:

- The specialist in ARTC's network agrees to a treatment plan for you.
- The specialist provides your PCP with updates on your condition and treatment plan.
- The specialist's services to be provided are part of the benefits covered by ARTC.

NOTE: If your specialist refers you to another specialist, your specialist may need to obtain authorization by ARTC and your PCP.

Self-Referrals

You may self-refer for certain covered services. No approval is required from your PCP or ARTC for these services.

You may receive benefit coverage for the following services whether or not the doctor is in the ARTC provider network.

- Emergency and Behavioral Health services.
- Family Planning services and supplies.
- Women's routine preventive health services.
- Treatment of women's acute health conditions (i.e. treatment of sexually transmitted diseases).
- Maternity care.

Urgent Care – After Hours

Urgent Care is not Emergency Care. Urgent Care is needed when you have an injury or illness that must be treated within 48 hours. It is usually not life threatening, yet you cannot wait for a visit to your PCP.

Only go to the emergency room if your doctor tells you to go or you have a life-threatening emergency. When you need urgent care, follow these steps:

- **Call your PCP.** The name and phone number are on your ARTC ID card. Your PCP may give you care and directions over the phone.
- **If it is after hours and you cannot reach your PCP, call the Nurse Advice Line at 1-866-282-6280 (TDD/TTY: 711).** You will be connected to a nurse. Have your ARTC ID card number handy. The nurse may help you over the phone or direct you to other care. You may have to give the nurse your phone number. During normal office hours, the nurse will assist you in contacting your PCP. If you are told to see another doctor or to go to the nearest hospital emergency room, **bring your ARTC ID card**. Ask the doctor to call your PCP or ARTC.

Emergency Care

ARTC covers emergency medical services 24-hours a day, seven days a week. Emergency services means covered inpatient and outpatient services that are 1) furnished by a provider that is qualified to furnish these services, and 2) needed to evaluate or stabilize an emergency medical condition. An emergency medical condition means a serious impairment from an accidental injury or an onset of what reasonably appears to be a serious dysfunction of any bodily organ or part, when the lack of medical attention could be expected by a reasonable person to result in jeopardy to a member's health or, in the case of a pregnant woman, the health of her unborn child.

Emergency rooms are for Emergency Services. If you have an Emergency Medical Condition, call 911 or go to the nearest hospital. You do not need a doctor's approval. Services will be covered. If you are not sure if it is an emergency or if you can, call your PCP first. Your PCP will tell you what to do. If your PCP is not available, a doctor taking calls can help. There may be a message telling you what to do. You can also call Nurse Advice Line, our 24-hour medical advice line at 1-866-282-6280 (TDD/TTY: 711) (TDD/TTY: 888-282-6428) if you have questions. If we instruct you to seek emergency services, it will be covered.

It is okay if the hospital does not belong to the ARTC network. You can use any hospital if it is an emergency medical condition. It is helpful if you, or someone acting on your behalf calls your PCP and ARTC so your PCP can provide or arrange for any follow-up care that you may need. We will also help you get follow-up care. Call Customer Service at

1-866-282-6280 (TDD/TTY: 711) (TDD/TTY: 888-282-6428). We will not deny payment prior to 10 calendar days of seeking Emergency Services.

Some examples of when and when not to use the emergency room are as follows:

WHEN TO GO to the ER

- Broken bones
- Gun or knife wounds
- Bleeding that will not stop
- You are pregnant, in labor and/or bleeding
- Severe chest pain or heart attack
- Drug overdose
- Poisoning
- Bad burns
- Shock (you may sweat, feel thirsty or dizzy or have pale skin)
- Convulsions or seizures
- Trouble breathing
- Suddenly unable to see, move or speak
- Severe dental pain or swelling

WHEN NOT TO GO to the ER

- Flu, colds, sore throats, and earaches
- A sprain or strain
- A cut or scrape not requiring stitches
- To get more medicine or have a prescription refilled
- Routine or preventive dental care
- Diaper rash

Post-Stabilization Services

These are services that are needed to stabilize your condition after an emergency. They do not require prior authorization. It does not matter whether you receive the emergency care in or outside of the ARTC network. We will still cover services to make sure you are stable after an emergency.

What if I/My Child Needs to be Admitted to a Hospital?

If you/your child needs to be admitted to a hospital for inpatient hospital care, your doctor must call ARTC to let us know about the admission. If you/your child receive inpatient services without notifying ARTC of the admission, you may be billed for the hospital stay. ARTC will follow you/your child's care while in the hospital to ensure that you/your child gets the proper care. The discharge date from the hospital will be based only on medical need to remain in the hospital. When medical needs no longer require hospital services, ARTC and you/your child's doctor will set a hospital discharge date.

If you do not agree with a decision to discharge you from the hospital, you have the right to ask for a review of the decision. This is called an appeal (see Appeals section).

Transportation Services

GAS REIMBURSEMENT

Need help getting to your healthcare appointments? Gas reimbursement can help you get there.

- If you have a car, you can receive .40 cents per mile to get to and from your healthcare appointments.
- The same amount can be paid to your friend, relative, or neighbor who drives you.

What types of appointments qualify for gas reimbursement?

Gas reimbursement is allowed for any healthcare appointment that is covered on your benefit plan with ARTC. This includes trips to your primary care provider, eye exams, dental visits and more.

How can I receive gas reimbursement?

1. Call 1-877-917-8162 **at least 30 minutes** before your scheduled appointment
2. Say "Transportation" or "Ride" or press the number "4"
3. Then press the number "1" to schedule transportation
4. A reservation specialist will tell you how to get a trip voucher. A trip voucher must be completed to receive gas reimbursement payment
5. Make sure to write down your job/trip number given to you by the reservation specialist. You will also write down the name and address of the driver
6. ***Your doctor/counselor must sign the trip voucher to show you were at the scheduled appointment in order for gas reimbursement to be paid to you or your driver**

Before mailing in your trip voucher for payment:

1. The job/trip number **must** be written on the voucher. The job/trip number was given to you when you made the first phone call.
2. Confirm the name and address of the driver with the reservation specialist.
3. Fill in all the blanks on the voucher, but do not fill in the Physician/Clinician Signature space since that part must be signed at your appointment by the doctor/counselor.
4. If you go to your healthcare appointment more than once per month, you can put several trips on one voucher.
5. **Important!** Only you or the person's name you gave as the driver at the time of the reservation will be paid. This means that only you or your driver (friend, family, or neighbor) will receive the payment. If you have different drivers, you must submit a separate voucher for each driver. You can make copies of the blank voucher if you need more than one.
6. **Important!** Timely filing does apply to your gas reimbursement voucher. Gas reimbursement vouchers MUST be received within 180 days of the trip date. Gas reimbursement vouchers received 180 days after the trip date will not be paid.

Mail completed trip voucher to:

LogistiCare Claims Department
Arkansas Gas Reimbursement
2552 West Erie Drive, Suite 101
Tempe, AZ 85282

EMERGENCY TRANSPORTATION SERVICES

ARTC covers emergency ambulance ground transportation to the nearest hospital for emergency care. **Ambulance transportation to the hospital emergency room in non-emergency situations is not a covered service under ARTC. You may have to pay for it.** Ambulance transportation from a healthcare facility to another healthcare facility is covered only when it is medically necessary. It also has to be arranged and approved by an ARTC network provider.

NON-EMERGENCY MEDICAL TRANSPORTATION SERVICES (NEMT)

NEMT stands for Non-Emergency Medical Transportation. NEMT should only be used when you do not have a way to get to your in-network healthcare appointment. We may use public transportation or bus tokens, vans, taxi, or even an ambulance, if necessary to get you to your healthcare appointment. ARTC will give you a ride that meets your needs. You do not get to choose what kind of car or van or the company that will give you the ride.

What are the NEMT guidelines for services?

- You must be enrolled with ARTC on the day of your appointment.
- If you have not met your spenddown, you may have to pay for your trip. Members with a spenddown can apply these transportation costs to their spenddown.
- **Use if no other free transportation options are available to you such as volunteer, community, or other.**
- Some people do not get NEMT as part of their benefits. To check, call Customer Service at 1-866-282-6280 (TDD/TTY: 711).
- Children who are under age 17 must have an adult ride with them.
- We will only pay for one child and one parent/guardian and/or an attendant if your child is under age 21 and needs to be away from home overnight or needs someone to be with him/her. We will not pay for other children or adults.

What healthcare services can I get NEMT to take me to?

- Any healthcare appointment that is covered on your benefit plan with ARTC. This includes trips to your primary care provider, eye exams, or dental visits, and more.
- The appointment is to a healthcare provider near where you live. If the provider is far away, you may need to say why you are going to this provider and get approval from ARTC. There are rules about how far you can travel to a health care appointment and get a ride.
- Transportation is available for services received within the State of Arkansas or to an approved Arkansas border city provided that the member is traveling to the closest available provider for his or her medical condition. Reimbursement is not made if the member chooses to travel to another community for a service that is already available in his or her community. NEMT guidelines are for in-state and approved border cities, not for out-of-state transportation.

How do I use the NEMT program?

To schedule a NEMT ride, **you must call at least 3 days before the day of the in-network appointment or you may not get a ride.** You may be able to get a ride sooner if your healthcare provider gives you an urgent care appointment. **If the appointment is urgent, you must say this when calling to schedule your trip.** Call Transportation at 1-877-917-8162. You can also call ARTC Customer Service at 1-866-282-6280 (TDD/TTY: 711). Say “Transportation” or “Ride” or press the number “4.” If you have an emergency, dial 911, or the local emergency phone number.

Pharmacy

Pharmacy Program

You can get prescriptions through your ARTC coverage if you go to a pharmacy that accepts ARTC members. There are some medications that may not be covered through ARTC. A participating ARTC pharmacy can let you know what medications are not covered and help you find medications that are covered. If you have questions regarding what medications are covered by ARTC, contact ARTC's Member Services for help.

Preferred Drug List (PDL)

The Preferred Drug List (PDL) is a list that shows some of the drugs covered under the pharmacy benefit. This list is updated monthly by the Arkansas Medical Assistance Program. You can find your PDL here: http://www.kdheks.gov/hcf/pharmacy/download/PDLList.pdf

Prior Authorization

Some medications have limits or require prior approval before your prescription can be filled. If prior approval is required, the pharmacy will inform your physician. If your physician feels you have a medical reason to receive the medication, they can can provide information about your health to ARTC to request coverage authorization. If ARTC does not grant the approval, you and your physician will be notified of the decision. You will also be given instruction on how to file an appeal. (See the ***Member Satisfaction*** section). Your doctor may need to send a request for prior authorization if:

- A drug is listed as non-preferred on the PDL or if certain conditions need to be met prior to you receiving the drug.
- You are getting more of the drug than is usually prescribed.
- There are other drugs that should be tried first.

Emergency Medication Supply

If your physician cannot be reached to approve a prescription that requires prior approval, you may be able to get a 72-hour (three-day) emergency supply. Pharmacies that accept ARTC members are authorized to provide a 72-hour supply. Narcotic medications are excluded from the emergency supply benefit. If you have recently been released from a medical facility or had an emergency department discharge, please call ARTC Customer Service for information on coverage. If you are traveling and have an emergency need for a medication and are outside of Arkansas, you will need to pay for the medication and submit the paid receipt with the prescription information to ARTC.

Over-the-Counter Medications

Arkansas Total Care provides coverage for a limited selection of over-the-counter (OTC) medications. The quantity of the OTC medication that can be obtained is determined by the appropriate course of therapy for the medical situation. In order for an OTC medication to be covered, it must be prescribed by a physician. If you purchase OTC medications without a prescription, ARTC will not cover those medications.

Excluded Drugs

Some medications are not covered by ARTC. These include, but are not limited to:

- Drug Efficacy Study Implementation (DESI) drugs – (medications are not proven effective)
- Identical, Related, and Similar (IRS) drugs – (brands that have a generic substitute)
- Symptomatic relief of cough and cold products
- Medications used for cosmetic purposes or hair growth
- Fertility agents
- Gender-specific medications if prescribed to the gender for which they are not FDA- approved or medically necessary
- Drugs used to treat erectile dysfunction
- Drugs used for weight loss (with the exception of those requiring prior authorization) or weight gain
- Over-the-counter products (except those listed on the Preferred Drug List)

Filling a Prescription

ARTC covers many prescription medications. Most Arkansas pharmacies provide services to ARTC members. You must show your ARTC ID card and any other medication benefit card you have (such as a Medicare Card or another private insurance carrier) at each visit to the pharmacy. If you are asked to pay at the pharmacy, please call ARTC Customer Service. If you have a spenddown, you will need to meet your spenddown before ARTC will cover your medications. If you need help finding a pharmacy or have trouble getting your medications, visit ArkansasTotalCare.com or call: 1-866-282-6280 (TDD/TTY: 711).

Lock-In

The Lock-In program is designed to help members get consistent care from one prescribing provider, one hospital, and one pharmacy who knows the member's specific needs. When ARTC identifies a member over utilizing services, using multiple providers, or who may be at risk the member can be referred to the Lock-In committee. The Lock-In committee reviews the member's medical information and medications. If a pattern of over-utilization or concern is noticed, the member may be notified by letter that they have 6 months or less to correct the behavior. If the behavior does not improve, the member will be "Locked-In" to one prescribing provider, one hospital, and one pharmacy.

Upon lock-in, you will be notified of your lock-in status and your lock-in providers. If you go to other providers while on Lock-In, the service may not be covered. ***ARTC may waive the 6-month grace period at will.*** If you do not agree with a decision to place you in the Lock-In program, you have the right to ask for a review of the decision. This is called an appeal (see Appeals section).

If you have questions regarding the Lock-In process, you may call Customer Service at 1-866-282-6280 (TDD/TTY: 711).

Medication Therapy Management (MTM)

Medication Therapy Management (MTM) is another service provided to ARTC members to assist the member in improving their health.

Medication Therapy Management involves a conversation with your pharmacist to review the medications you are taking and your current health conditions. The pharmacist may talk with you in person or may call you on the phone. The pharmacist will answer questions you may have about taking your medications, like the side-effects of your medicine. The pharmacist will also review all of your medications, over-the-counter medications, and herbal treatments and make suggestions to you and possibly your physician based on clinical information. Participation in this program is encouraged to help ensure our members are receiving optimal medication therapy.

Health Management

Health Risk Screening

ARTC wants to know how we can better serve you. One way we do this is by asking you to fill out the Health Risk Screening form found in your Welcome Packet. This form gives us information to determine your needs. Once you fill out the form, please send it back to us right away in the postage-paid envelope we have provided for you.

You can also fill out this form on our website ArkansasTotalCare.com.

If you have questions about the form, please call Customer Service at 1-866-282-6280 (TDD/TTY: 711).

Care Management

We understand some members have special needs. In those cases, ARTC offers our members care management services to assist our members with special healthcare needs. If you have special healthcare needs or you have a disability, care management may be able to help you. We know this means more than just helping you to see a doctor. It also means helping you find your way through the healthcare system so you get the treatments and the social services you need. Our care managers are registered nurses or social workers who can help members understand their health problems. They can arrange care with your doctors. A care manager will work with you and your doctor to help you get the care you need.

Some of the benefits of care management are:

- Working with you to develop a care plan
- Speaking with you at scheduled times
- Interacting with your doctors
- Helping connect you with community programs and services
- Coordination and assistance with appointment scheduling

This service is for members who have complex medical conditions. Members who have complex medical conditions or need long term services or supports often see several doctors and may need medical supplies or help at home.

Conditions may include:

- Sickle Cell
- Multiple Sclerosis
- Kidney or Renal Disease
- Organ Transplants
- HIV/AIDS
- Hemophilia

Call Customer Service at 1-866-282-6280 (TDD/TTY: 711) if you would like to learn more or are interested in care management.

Disease Management

ARTC has several programs to improve the health of our members. Not all members need care management. We know this means more than just helping you to see a doctor. It also means helping you find your way through the healthcare system so you get the treatments and the social services you need. It also means helping you understand and manage your health conditions. We do this through our disease management programs. Members are provided education and personal help from ARTC staff. The goal of this service is to add to the quality of your care and help you to improve your health.

ARTC has a program called Healthy Solutions for Life to give disease management services to our members. Healthy Solutions for Life coaches know a lot about conditions like:

- Asthma
- Diabetes
- High blood pressure
- Heart problems
- Weight management
- Smoking cessation
- Puff-Free Pregnancy
- COPD

All of our programs are geared toward helping you understand and actively manage your health. We are here to help you with things like:

- How to take medicines
- What screening tests to get
- When to call the doctor

We will help you get the things you need. We will provide tools to help you learn and take control of your condition. For more information call Customer Service at 1-866-282-6280 (TDD/TTY: 711). You can ask to speak to a Health Coach.

In-home visits are available for members enrolled in the asthma and COPD disease management coaching programs. An in-home respiratory therapist will complete a physical assessment and encourage family participation. The member and health coach will review the member's problem-solving skills and ensure he/she has an understanding of the self-management plan. In-home visits also include an assessment of the member's living environment. The member should discuss the need for in-home visits with his/her health coach.

Behavioral Health Services

ARTC will cover your behavioral health needs. You may go to any behavioral health provider in our network. Be sure to look at the ARTC provider list located on the website ArkansasTotalCare.com or by calling Customer Service. Behavioral healthcare includes care for people who abuse drugs or alcohol or need other behavioral health services. Call 1-866-282-6280 (TDD/TTY: 711) to get behavioral health services.

DRUG AND ALCOHOL SERVICES

Behavioral Health refers to mental health, and drug & alcohol treatment. Sometimes talking to friends or family members can help you work out a problem. When that is not enough, you should call your doctor or ARTC's behavioral healthcare provider. ARTC has a group of specialists to help you and your child with any drug and alcohol problems. You do not need a referral from a doctor for these services. We will help you find the right provider. Call 1-866-282-6280 (TDD/TTY: 711) to get help right away. You can call 24 hours a day, seven days a week.

HOW DO YOU KNOW IF YOU OR YOUR CHILD NEEDS HELP?

Help might be needed if you or your child:

- Cannot cope with daily life
- Feels very sad, stressed or worried
- Is not sleeping and/or eating well
- Wants to hurt self or others
- Sees or hears things that other people do not
- Drinks more often and/or is using drugs
- Has problems at work, school or home

When you or your child have a behavioral health or drug abuse problem, it is important for you to work with someone who knows how to help. Arkansas Total Care staff can get you a provider who can best assist your needs.

HOW CAN ARTC HELP?

We have care coordinators that can assist you with the following:

- Transportation services
- Locating provider(s)
- Scheduling appointments
- Interpretation services

WHAT TO DO IN A BEHAVIORAL HEALTH EMERGENCY

You should call 911 if you or your child is having a life-threatening behavioral health emergency. You can also go to your local community health center, a crisis center or the nearest emergency room. You do not have to wait for an emergency to get help. Call Sunlflower's behavioral health at 1-866-282-6280 (TDD/TTY: 711) for someone to help you or your child with depression, behavioral illness, substance abuse or emotional questions. You can call 24 hours a day, seven days a week.

WHAT TO DO IF YOU OR YOUR CHILD IS ALREADY IN TREATMENT

If you or your child is already getting care, ask your provider if they are in ARTC's behavioral health network. If the answer is yes, you do not need to do anything. If the answer is no, call 1-866-282-6280 (TDD/TTY: 711). We will ask your and/or your child's provider to join our network. We want you or your child to keep getting the care needed. If the provider does not want to join the behavioral health network, we will work with the provider to keep caring for you or your child until medical records can be transferred to an ARTC network behavioral health provider.

CentAccount® Program

ARTC has a program to reward you for completing healthy behaviors. The CentAccount Rewards program gives you rewards on a card to be used for certain purchases. Below shows you how much you can earn for healthy behaviors.

HEALTHY ACTIVITY	REWARD
Complete an annual Health Risk Screening – One per calendar year.	$10
Child Well Visit with PCP – One per calendar year; age 2-20.	$10
Infant Well Visit – All 6 visits completed with a PCP in first 15 months. These visits are recommended before 30 days old and at 2, 4, 6, 9, 12 and 15 months old.	$10 per infant well visit for a total of $60.
Immunizations Bonus - MMR and VZV (given between 12-15 months)	$10 bonus for each immunization
Human Papilloma Virus (HPV) Vaccination – Males and females, ages 9-12. Must get 2 shots in the HPV series in a 12-month period.	$15 for complete series in 12 months.
Diabetes Management – Have 1 or 2 HbA1c lab draws to earn $10 for each. You can earn a maximum of $20 per yr. (Ages 18-75.) ***To earn an additional $50,*** *complete an A1C, kidney screening and dilated eye screening. Must have all 3 screenings in the year. (Ages 18-75.)*	• $10 HbA1c with max of 2 per yr. for total of $20 • $50 if all 3 services are met in addition to the HbA1c
Notice of Pregnancy to ARTC in the first trimester	$15
Prenatal Visit – 3rd, 6th & 9th (each visit at $15).	$45
After Baby Delivery – Follow-up visit	$10

Your CentAccount card can be used to purchase items at participating stores. New rewards are added to your card for healthy behaviors, so do not throw away your CentAccount card. If the card must be replaced, there may be a deduction from your earned rewards. Some of the items you can buy with your card include, but are not limited to:

- Baby care
- Groceries
- Personal care
- Women's care
- Over-the-counter medicines

More information on the CentAccount program can be found on our website at ArkansasTotalCare.com. You can also call Customer Service at 1-866-282-6280 (TDD/TTY: 711) for more information.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a preventive healthcare program for members ages birth to 21 years old. Children and young people need to see their doctor regularly even when they are not sick. This chart shows when babies, children and young adults need to see their doctor for a health check. We don't want your child to miss any key steps toward good health as they grow. To help remind you of check-ups, ARTC may call you or send you a reminder in the mail.

Doctors and nurses will examine your child or teen. They will give shots for disease prevention when necessary. Shots are important to keep your child healthy. They will also ask questions about health problems and tell you what to do to stay healthy. If there is a problem found during the checkup, your doctor can send you to a specialist.

AGE GROUP	HEALTH CHECK SCHEDULE	DENTAL PERIODICITY SCHEDULE
Infancy	• Birth • 3 to 5 days • By 1 month • 2 months • 4 months • 6 months • 9 months	• When first tooth shows, no later than 12 months. • Repeat every 6 months.
Early Childhood	• 12 months • 15 months • 18 months • 24 months • 30 months • 3 years • 4 years	• Every 6 months
Middle Childhood	• Every year for ages 5-10 years	• Every 6 months
Adolescence	• Every year for ages 11 until age 21	• Every 6 months

For help making an appointment with your doctor, please call Customer Service at 1-866-282-6280 (TDD/TTY: 711).

Family Planning Services

ARTC covers family planning services. You can get these services and supplies from providers that are not in our network. You do not need a referral. These services are free for our members. These services are voluntary and confidential, even if you are less than 18 years old.

Some examples of family planning services are:

- Education and advice from trained personnel to help you make choices
- Information about birth control
- Physical exams

- Follow-up visits
    - Immunization services
    - Pregnancy tests
    - Birth control supplies
    - Tests and treatment of STDs (sexually transmitted diseases)

WHEN YOU ARE PREGNANT

Keep these points in mind if you are pregnant now or want to become pregnant:

- **Go to the doctor as soon as you think you are pregnant.** It is important for your health and your baby's health to see a doctor as early as possible. Seeing your doctor early will help your baby get off to a good start. It's even better to see your doctor before you get pregnant to get your body ready for pregnancy.
- **Make an appointment with your dentist** for a cleaning and checkup.
- **Set a goal to live a healthier lifestyle.** Healthy lifestyle habits include exercising, eating balanced healthy meals, and resting for 8-10 hours at night.

PREGNANCY AND MATERNITY SERVICES

There are things you can do to have a ***safe and healthy pregnancy.*** See your doctor about any medical problems you have, such as diabetes and high blood pressure. Do not use tobacco, alcohol, or non-prescribed drugs either now or while you are pregnant. ARTC recommends that you see your doctor before becoming pregnant if you have experienced any of the following problems:

- You have had three or more miscarriages.
- You have given birth to a premature baby (this means the baby came before 37 weeks of pregnancy), or a "preemie."
- You gave birth to a stillborn baby.

A note about folic acid: Folic acid is a very important nutrient that can help you have a healthier baby. You should take folic acid before you become pregnant or as soon as you find out you are pregnant. Some foods that have folic acid in them include:

- Orange juice
- Green vegetables
- Beans
- Peas
- Fortified breakfast cereals
- Enriched rice
- Whole wheat bread

It is difficult to get enough folic acid from food alone. Ask your doctor about taking prenatal vitamins and see your doctor as soon as you think you are pregnant. If you have questions about folic acid or your pregnancy, call Customer Service at 1-866-282-6280 (TDD/TTY: 711).

PREGNANCY PROGRAM – START SMART FOR YOUR BABY®

Start Smart for Your Baby (Start Smart) is our special program for women who are pregnant. ARTC wants to help you take care of yourself and your baby through your whole pregnancy. Information can be provided to you by mail, telephone, and through the Start Smart website, www.startsmartforyourbaby.com. Our Start Smart staff can answer questions and give you support if you are having a problem. We can even arrange for a home visit, if needed.

If you are pregnant and smoke cigarettes, ARTC can help you stop smoking. We have a special smoking cessation program for pregnant women. It is available at no cost to you. The program has trained healthcare clinicians who are ready to build one-to-one contacts with you. They will provide education, counseling and the support needed to help you quit smoking. Working as a team over the telephone, you and your health coach can develop a plan to make changes in your behavior and lifestyle. These coaches will encourage and motivate you to stop smoking.

We have many ways to help you have a healthy pregnancy. Before we can help, we need to know you are pregnant. Please call Customer Service at 1-866-282-6280 (TDD/TTY: 711) as soon as you learn you are pregnant. We will help you set up the special care that you and your baby need.

Don't forget, you can also earn CentAccount rewards for attending pregnancy visits. However, you have to enroll in the Start Smart program to earn rewards.

Child or Adult Abuse

Any ARTC member that has reason to suspect a child, adult or elderly person has been harmed or abused should file a report immediately. File the report with the Arkansas Protection Report Center at 1-800-922-5330 or file it with your local law enforcement agency.

Personalized Outreach – MemberConnections®

MemberConnections is a program with outreach teams that can help you understand your health coverage and community resources. MemberConnections can provide one-on-one services at your home or over the phone. They can help you build a relationship with your doctor and help you understand your health benefits. If you are in need of transportation, food, clothing, shelter, or other health programs, MemberConnections can help. Call Customer Service at 1-866-282-6280 (TDD/TTY: 711) for information.

Cell Phones through MemberConnections®

CONNECTIONSPLUS CELL PHONE

ARTC can lend a cell phone to our members in case management who do not have access to a regular phone. ConnectionsPlus cell phones are programmed to make calls to and receive calls from the Arkansas Total Care Care Management team, the member's doctors, and the member's family. These phones have unlimited texting and calls to the health plan that do not use minutes.

To learn more about the program, please contact Customer Service at 1-866-282-6280 (TDD/TTY: 711) or log onto our website at ArkansasTotalCare.com.

SAFELINK CELL PHONES

If you are not in case management, you may be eligible for a SafeLink phone. This is a federal program that gives qualifying members a free cell phone and 250 minutes or texts per month. The SafeLink program gives you the ability to make and receive calls from your doctors, nurses, pharmacy, 911, family, and friends. In the SafeLink program, you will have unlimited calling to ARTC's toll-free number 1-866-282-6280 (TDD/TTY: 711). You can call ARTC's Member Services, Case Managers, or MemberConnections, and it will not count towards your minutes. If you are in case management, your Case Manager may have more SafeLink minutes loaded to your SafeLink phone.

Member Satisfaction

We hope you will always be happy with us and our network providers. If you are not happy, please let us know. ARTC has steps for handling any problems you may have. ARTC offers all of our members the following processes to achieve member satisfaction:

- Grievance Process
- Appeal Process
- State Fair Hearing

ARTC keeps records of each grievance and appeal filed by our members or by their authorized representatives. ARTC also keeps records of the responses to each grievance and appeal. These are kept for seven years.

Grievance Process

Arkansas Total Care wants to fully resolve your problems or concerns. A grievance is an expression of dissatisfaction. You can file a grievance or protest to ARTC about a wrong committed to you by the health plan or one of its providers. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, acts of rudeness by a provider or employee, or failure to respect a member's rights.

GRIEVANCE BASICS

- ARTC will not treat you differently if you file a grievance.
- Filing a grievance will not affect your healthcare services.
- A grievance may be filed verbally by calling the plan or in writing within 180 days of the event.
- For ARTC to completely review your concern, please provide your first and last name, Medicaid ID, phone number where we can reach you, what you are unhappy with, and what you would like to happen when contacting us to file a grievance.
- You may allow someone to file a grievance for you. To do so, you must sign a form giving that person permission to act on your behalf. To obtain this form, contact Customer Service or get it from the ARTC website. You will need to fill it out and return it by mail or fax before ARTC can review your concern with the person you designate.
- Information or documents that support the grievance can be sent to ARTC by mail or fax.
- Documentation used to make the decision about the grievance will be provided to you upon your request.
- ARTC will provide assistance in filling out any forms needed for the process.
- If you do not like the resolution provided by ARTC for your grievance, you can ask for them to review the decision.
- The Medicaid Ombudsman is a resource to members for assistance with rights and responsibilities under Medicaid, when you need help solving a problem with ARTC, when you do not think you are getting the care you need, or when you feel your rights are violated. Please refer to page 44 for more information
- You may request a grievance to be reviewed as clinically urgent. Clinically urgent grievances will be resolved in 72 hours. However, if the clinically urgent grievance request does not meet criteria as clinically urgent it will be handled in the standard grievance timeframe of 30 calendar days.

ARTC wants to resolve your concerns quickly. If we cannot resolve your concern in 30 calendar days, we

can ask for an extension to gather more information to assist you. You can also ask for an extension. The request for an extension to resolve the grievance must be made 2 business days before the 30 calendar day deadline to the state. If an extension is needed, we will notify you in writing of the reason we need more time to resolve your concern.

GRIEVANCE PROCESS TIMELINE:

Step 1:

Member files grievance by calling Customer Service, or by sending a fax or letter to ARTC.

Step 2:

ARTC sends a letter within 10 calendar days of receipt of the grievance to let member know the grievance has been received, unless the grievance was resolved on the same day it was received by ARTC.

Step 3:

ARTC will resolve the grievance and send the member a notice of their decision within 30 calendar days of receipt of the grievance.

WHERE TO SEND YOUR GRIEVANCE

To file a grievance, please contact us at:

Arkansas Total Care Quality Department
8325 Lenexa Drive, Suite 200
Lenexa, KS 66214

Phone: 1-866-282-6280 (TDD/TTY: 711)
TDD/TTY 1-888-282-6428
Fax: 1-888-453-4755

Appeal Process

An appeal is a request to review an action by ARTC. An action is the denial, limiting of a member service, or failure by ARTC to provide service timely or to act within timeframes. An appeal of an action is a request for ARTC to review the action of concern, existing or additional documentation, and make an appeal decision. You can request this review by phone or in writing. You may not appeal a payment issue for a provider. If you are receiving a bill from a provider, please contact ARTC.

APPEAL BASICS

- ARTC will not treat you differently if you file an appeal.
- An appeal must be filed within 33 calendar days of the date of the letter noting an adverse action that is sent to you. This letter may be called “Notice of Action” or “Notice of Adverse Action or Determination.” If you receive a letter and you don’t know if it is an action letter, please contact us to review it with you.
- An appeal may be filed by phone, fax, or in writing.
- Information on how to appeal will be included in the action letter you receive.

- You may allow someone including an attorney, family member, provider or other authorized representative to file an appeal for you. To do so you must sign a form giving that person permission to act on your behalf. This form will be included in the letter you receive explaining your appeal rights, is found at the back of this handbook or can be found by contacting Customer Service or from the ARTC website. You will need to fill it out and return it by mail or fax before ARTC can review your concern with the person you designate.
- Information or documents that support the appeal can be sent to ARTC by mail or fax.
- ARTC will provide assistance in filling out any forms needed for the process.
- For appeals related to services that put your health at immediate risk, you may file an expedited appeal. These will be reviewed within 3 calendar days of the request. These can be submitted verbally and do not have to be in writing to ARTC. To get an expedited appeal, please call ARTC at 1-866-282-6280 (TDD/TTY: 711). ARTC will make reasonable effort to call you with the appeal decision. A member may not file a State Fair Hearing at the same time as an expedited appeal. If the appeal is found not to put the member health at immediate danger, it may be changed to a standard appeal. Reasonable effort will be made to notify verbally that the expedited appeal will be handled in standard timeframe. Written notice acknowledging appeal as standard will be sent within 2 calendar days and will be resolved in 30 calendar days.
- A State Fair Hearing may be requested once the member has completed the internal process of ARTC appeal. State Fair Hearing requests must be made within 33 calendar days of the letter notifying of the decision on your appeal by ARTC.
- You have the right to have a representative of your choice at the State Fair Hearing. You will receive the rules that govern representation at a State Fair Hearing in the action letter you receive.
- A Fair Hearing includes ARTC as well as you and your representative, or the representative of a deceased member's estate.
- ARTC wants to resolve your concerns quickly, and will resolve your appeal within 30 calendar days of you filing it with us. If we cannot resolve your appeal in the timeframes noted, we can ask for an extension to gather more information to assist you. You or your provider can also ask for an extension. If an extension is needed, we will notify you in writing of the reason we need more time to resolve your concern. Requests for extensions must be made 2 business days before the 30 calendar day deadline to the state.

WHERE TO SEND YOUR APPEAL

Please send appeal requests to the address in your action letter or:

Arkansas Total Care Quality Department
8325 Lenexa Drive, Suite 200
Lenexa, KS 66214

Phone: 1-866-282-6280 (TDD/TTY: 711)
TDD/TTY 1-888-282-6428
Fax: 1-888-453-4755

WHAT HAPPENS TO MY SERVICES WHILE I AM APPEALING THE ACTION?

Continuation of Non-HCBS Services:
Services may be continued during the appeal or State Fair Hearing if all of the following criteria are met:

1. Arkansas Total Care's action reduces, suspends or terminates previously authorized services.
2. Request for appeal is filed timely within 33 calendar days from the date on the notice of action mailed.
3. Request for continuation of services is made within 10 calendar days from the mailing date on the notice of action or within 10 days of the date the reduction, suspension or termination of previously authorized services goes into effect.
4. The services were ordered by authorized provider.
5. The original period covered by the authorization has not expired.

For members who are receiving Non-HCBS Services, if the decision of the appeal or state fair hearing is not in the member's favor and ARTC's decision is upheld, then ARTC may recover the costs of the services provided to the member while the appeal or state fair hearing was in process from the member.

Continuation of HCBS Services:
Continuation of HCBS Services will be continued during the appeal or State Fair Hearing process if all of the following criteria are met:

1. Arkansas Total Care's action reduces, suspends or terminates previously authorized HCBS Program services or benefits.
2. Request for appeal or State Fair Hearing is filed timely within 33 calendar days from the date on the notice of action mailed.
3. The services were ordered by authorized provider.
4. The original period covered by the authorization has not expired.
5. If you requested different HCBS Program services to replace your previously authorized HCBS Program services, and Arkansas Total Care authorized the new HCBS Program services, your previously authorized HCBS Program services must be terminated to allow your new HCBS Program services to begin. If your new HCBS Program services will begin within 33 days of the date of the Notice of Action terminating your previously authorized HCBS Program services, your previously authorized HCBS Program services will be continued only until your new HCBS Program services begin.

For members who are receiving HCBS Services, if the decision of the appeal or state fair hearing is not in the member's favor and ARTC's decision is upheld, the member will not have to pay ARTC for the HCBS services and benefits provided during the appeal or State Fair Hearing was in process unless fraud has occurred.

For members who receive Non-HCBS and HCBS services, the services and benefits continued pending the outcome of the appeal process shall end 10 calendar days following the notice containing the appeal decision for the termination, suspension or reduction of previously authorized services. If a state fair hearing is requested within 10 calendar days from the date on the notice of the appeal decision, the services and benefits will be continued through the date of the State Fair Hearing decision.

Benefits will continue during the appeal or State Fair Hearing process until one of the following happens:

1. Member withdraws the appeal.
2. Member does not request appeal within 33 calendar days of the date on the notice of action or does not request State Fair Hearing within 10 calendar days from date on the appeal resolution notice.

3. State fair hearing officer issues hearing decision that is not in favor of the member.
4. Time period or service limits of previously authorized service has been met.
5. Member or member guardian requests previously authorized HCBS services or benefits to end and be replaced with another HCBS service or benefit.

Requests for future services are not included under continuation of benefits.

If you do not know if the services you are receiving are Home and Community Based Services (HCBS), please contact Customer Service at 1-866-282-6280 (TDD/TTY: 711).

APPEAL PROCESS TIMELINE:

Step 1: Member files appeal by calling Customer Service, or by sending a fax or letter to ARTC within 33 calendar days of the date on the notice of action.

Step 2: Member may request to have services continue while they are waiting for ARTC to make a decision, but this request must be made in 10 calendar days from the mailing date on the notice of action letter for continuation of non-waiver services. For HCBS services, services provided will continue without change until the appeal process is complete.

Step 3: ARTC sends a letter within 5 calendar days of the receipt of the appeal to let member know the appeal has been received.

Step 4: ARTC will resolve the appeal and send the member a notice of their decision within 30 calendar days of receipt of the appeal.

Step 5: If a member is not satisfied with the ARTC appeal decision they have the right to request a State Fair Hearing within 33 days of the date on notice of action. If members want their services continued during the State Fair Hearing, they must request a state fair hearing within 10 calendar days of the date of the notice of appeal decision for both HCBS and Non-HCBS services.

STATE FAIR HEARING FOR APPEALS

You or your representative which can be an attorney, family member, friend, spokesperson, provider or other authorized representative, can ask the Arkansas Office of Administrative Hearings to review ARTC's appeal decision. You can do this in three ways:

1. Call ARTC and ask us to file a State Fair Hearing request.
2. Send a letter to ARTC and ask us to file a State Fair Hearing request.
3. Complete the Request for Administrative Hearing form included with your action letter and mail it to:

   Office of Administrative Hearings
   1020 S. Arkansas Ave.
   Topeka, Arkansas 66612

WILL I HAVE TO PAY FOR MY SERVICES AFTER AN APPEAL OR STATE FAIR HEARING?

For members who are receiving **Non-HCBS Services**, if the decision of the appeal or State Fair Hearing is not in the member's favor and ARTC's decision is upheld, then ARTC may recover the costs of the services provided to the member while the appeal or State Fair Hearing was in process from the member.

For members who are receiving **HCBS Services**, if the decision of the appeal or State Fair Hearing is not in the member's favor and ARTC's decision is upheld, the member will not have to pay ARTC for the HCBS services and benefits provided during the appeal or State Fair Hearing unless fraud has occurred.

If you do not know if the services you are receiving are Home and Community Based Services (HCBS), please contact Customer Service at 1-866-282-6280 (TDD/TTY: 711).

ADDITIONAL RESOURCE: MEDICAID OMBUDSMAN

The Medicaid Ombudsman is employed by the State of Arkansas Department for Aging and Disability Services and is available to assist Medicaid members regarding their rights and responsibilities under Medicaid. The Ombudsman helps Medicaid/Medicaid member and Arkansas Consumers with concerns about getting services needed through Medicaid which includes providing assistance to those served on the Home and Community Based Services (HCBS) waiver programs and those who get long-term care through Medicaid. The Ombudsman can help you:

- When you need help with a problem you can't solve by speaking with your Medicaid health plan.
- When you do not think that you are getting the care that you need.
- When you feel your rights are being violated.

You can reach the Medicaid Ombudsman at 1-855-643-8180, TTY 711, or by email at Medicaid.Ombudsman@kdads.ks.gov.

Waste, Abuse, and Fraud (WAF) Program

ARTC is committed to preventing, identifying and reporting all instances of waste, abuse and fraud. To report abuse, call ARTC's WAF Hotline at 1-866-685-8664. You do not need to give your name.

Waste, abuse, and fraud means that any member, any provider, or another person is misusing the Medicaid program or ARTC resources. This could include things like:

- Loaning, selling or giving your ARTC member ID card to someone.
- Misusing ARTC or Medicaid benefits.
- Billing ARTC for "free" services.
- Wrongful billing to ARTC by a provider.
- Billing ARTC for services not provided.
- Any action to defraud ARTC, or the Medicaid program.

Your healthcare benefits are given to you based on your eligibility for the Medicaid program. You must not share your ARTC Member ID Card with anyone. ARTC's network providers must also report any misuse of benefits to ARTC. ARTC must also report any misuse or wrongful use of benefits to Medicaid. If you misuse your benefits, you could lose them. Medicaid may also take legal action against you if you misuse your benefits.

If you think a doctor, a hospital, another ARTC member, or another person is misusing Medicaid or ARTC benefits, tell us right away. We will take action against anyone who is misusing the Medicaid program. Your call about waste, abuse, and fraud will be taken seriously.

Here is the address:

Arkansas Total Care
Compliance Department
8325 Lenexa Drive
Lenexa, KS 66214

Or you can call ARTC's Waste, Abuse, and Fraud Hotline at 1-866-685-8664. You do not need to give your name.

You can also report provider waste, abuse and fraud to the Arkansas Medicaid Fraud and Abuse Division at the address or phone number below:

Arkansas Attorney General's Office
Attn: Medicaid Fraud and Abuse Division
120 SW 10th Ave., 2nd Floor
Topeka, KS 66612-1597
866-551-6328 or 785-368-6220

What to Do if You Get a Bill

Be sure to talk with your doctor about services that are covered and services that are not covered. You should not be billed for services that are covered, as long as you follow plan rules. If you get a bill for a service that should be covered by ARTC, call your provider right away. Make sure your provider has all of your insurance information and knows to bill ARTC. If you still get bills from the provider after you give your insurance information, call Customer Service at 1-866-282-6280 (TDD/TTY: 711). We want to help. Do not pay the bill yourself.

If you ask for a service that is not covered by ARTC, your doctor will ask you to sign a statement saying you will pay for the service yourself. If you sign a statement saying you will pay for the non-covered service, then you are responsible for the bill. If you have any questions about a bill, call Customer Service at 1-866-282-6280 (TDD/TTY: 711).

Other Insurance

You must let ARTC and Medicaid know if you have other insurance coverage with another company. ARTC can help coordinate your other benefits with your other insurance company.

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Accidental Injury or Illness (Subrogation)

ARTC members who need to see a doctor for an injury or illness that was caused by another person or business must notify us of the incident as soon as possible. Please call our Customer Service at 1-866-282-6280 (TDD/TTY: 711) to let us know. When you call, we will need the name of the person or business at fault, their insurance company, and the names of any attorneys involved. Some examples of accidents or injuries that need to be reported to ARTC are:

- You are hurt in a car accident
- You are hurt on the job and/or have a worker's compensation claim
- You fall and/or get hurt in a store
- You have a Personal Injury or Medical Malpractice law suit

Member Rights and Responsibilities

Members are informed of their rights and responsibilities through the Member Handbook. ARTC network providers are also expected to respect and honor member's rights.

ARTC MEMBERS HAVE THE FOLLOWING RIGHTS:

- To get information about Arkansas Total Care, its services, its practitioners and providers and member rights and responsibilities.
- To give their ideas for "ARTC's member rights and responsibilities policy."
- To be treated with respect, dignity and privacy.
- To get information on care options in a way that they can understand, regardless of cost or coverage.
- To participate in decisions about their health care. This includes the right to refuse treatment.
- To seek second opinions.
- To get help with care coordination from the PCP's office.
- To not be restrained or secluded if doing so is:
    - Meant to force them to do something they do not want to do.
    - To punish them.
    - For someone else's convenience.
    - To get back at them.
- To express a concern or appeal about ARTC or the care it provides. To receive a response in a reasonable period of time.
- To receive a copy of their medical records upon request. (One copy is free of charge.) To ask that they be amended or corrected.
- To choose their health professional and long-term supports and services providers to the extent possible and appropriate, as per 42 CFR §438.6(m).
- To be given health care services as per 42 CFR §§ 438.206 through 438.210.
- To get health care services that are similar in amount and scope to those given under Medicaid Fee-For-Service. This includes the right to get health care services that will achieve the purpose for which the services are given.
- To get services that are fitting and are not denied or reduced due to:
    - Diagnosis
    - Type of illness
    - Medical condition
- To be given information in a manner and format they can understand as defined in the Provider Agreement and this Member Handbook. This includes
    - Enrollment notices
    - Informational materials
    - Instructional materials
- Treatment options and alternatives
- To get free oral interpretation services for all non-English languages.
- To be notified that interpretation services are

available and how to access them.
- To get adequate and timely information on ARTC's Physician Incentive Plan upon request.

ARTC MEMBERS HAVE THE FOLLOWING RESPONSIBILITIES:

- To inform ARTC of the loss or theft of an ID card.
- To inform ARTC, your provider and the State Medicaid program of any change of address or phone number.
- To present the ARTC ID card when using health care services.
- To be familiar with ARTC procedures to the best of their abilities.
- To contact ARTC to get information and have questions answered.
- To give providers accurate and complete medical information.
- To follow care prescribed by the provider or to let the provider know why treatment cannot be followed, as soon as possible.
- To keep appointments and follow-up appointments. To access preventive care services.
- To live healthy lifestyles and avoid behaviors known to be harmful.
- To understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
- To give accurate and complete information needed for care to ARTC and all their health care and support providers.
- To make their primary care provider aware of all other providers who are treating them. This is to ensure communication and coordination in care. This also includes behavioral health providers.
- To learn about ARTC coverage provisions, rules and restrictions.
- To ask questions of providers to learn the risks, benefits, and costs of treatment options. To make care decisions after carefully weighing all factors.
- To follow ARTC's grievance process outlined in this Member Handbook if there is a disagreement with a provider.
- To choose a primary care provider (PCP).
- To treat providers and staff with dignity and respect.

Advance Directives

Advance Directives are written instructions you create about the healthcare you want to receive when you are unable to speak for yourself. For example, under Arkansas law (KSA 65-28,101) an adult person can make an advance directive to withhold or remove life-giving care in the event of a terminal condition. This also includes planning treatment before you need it. All ARTC adult members have a right to make Advance Directives. ARTC will provide you with written information on Advance Directive policies and include applicable state laws. You can call Customer Service at 1-866-282-6280 (TDD/TTY: 711) for help in finding the form. You can also talk to your PCP about Advance Directives. Once completed, ask your PCP to put the form in your file.

Together, you and your PCP can make decisions that will set your mind at ease. It can help your PCP and other providers understand your wishes about your health. Advance Directives will not take away your right to make your own decisions and will work only when you are unable to speak for yourself. You will not be discriminated against for not having an Advance Directive.

Examples of Advance Directives include:

- Living Will
- Health Care Power of Attorney
- "Do Not Resuscitate" Orders

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Protecting Your Privacy

Notice of Privacy Practices

For help to translate or understand this, please call 1-866-282-6280 (TDD/TTY: 711) Hearing impaired TTY 1-888-282-6428.

Si necesita ayuda para traducir o entender este texto, por favor llame al telefono. 1-866-282-6280 (TDD/TTY: 711)

Interpreter services are provided free of charge to you.

COVERED ENTITIES DUTIES:

Arkansas Total Care is a Covered Entity as defined and regulated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Arkansas Total Care is required by law to keep the privacy of your protected health information (PHI). We must give you this Notice. It includes our legal duties and privacy practices related to your PHI. We must follow the terms of the current notice. We must let you know if there is a breach of your unsecured PHI.

This Notice describes how we may use and disclose your PHI. It describes your rights to access, change and manage your PHI. It also says how to use rights.

Arkansas Total Care can change this Notice. We reserve the right to make the revised or changed Notice effective for your PHI we already have. We can also make it effective for any of your PHI we get in the future. Arkansas Total Care will promptly update and get you this Notice whenever there is a material change to the following stated in the notice:

- The Uses and Disclosures
- Your Rights
- Our Legal Duties
- Other privacy practices stated in the Notice.

Updated notices will be on our website and in our Member Handbook. We will also mail you or email you a copy on request.

USES AND DISCLOSURES OF YOUR PHI:

Arkansas Total Care protects your PHI. We have privacy and security processes to help.

These are some of the ways we protect your PHI.

- We train our staff to follow our privacy and security processes.
- We require our business associates to follow privacy and security processes.
- We keep our offices secure.
- We talk about your PHI only for a business reason with people who need to know.
- We keep your PHI secure when we send it or store it electronically.
- We use technology to keep the wrong people from accessing your PHI.

INTERNAL PROTECTIONS OF ORAL, WRITTEN AND ELECTRONIC PHI:

The following is a list of how we may use or disclose your PHI without your permission or authorization:

- **Treatment** – We may use or disclose your PHI to a physician or other healthcare provider providing treatment to you. We do

this to coordinate your treatment among providers. We also do this to help us with prior authorization decisions related to your benefits.

- **Payment** – We may use and disclose your PHI to make benefit payments for the healthcare services you received. We may disclose your PHI for payment purposes to another health plan, a healthcare provider, or other entity. This is subject to the federal Privacy Rules. Payment activities may include:
  - processing claims
  - determining eligibility or coverage for claims
  - issuing premium billings
  - reviewing services for medical necessity
  - performing utilization review of claims.
- **Healthcare Operations** – We may use and disclose your PHI to perform our healthcare operations. These activities may include:
  - providing customer services
  - responding to complaints and appeals
  - conducting medical review of claims and other quality assessment and improvement activities
  - providing case management and care coordination.
- In our healthcare operations, we may disclose PHI to business associates. We will have written agreements to protect the privacy of your PHI with these associates. We may disclose your PHI to another entity that is subject to the federal Privacy Rules. The entity must also have a relationship with you for its healthcare operations. This includes the following:
  - quality assessment and improvement activities
  - reviewing the competence or qualifications of healthcare professionals
  - case management and care coordination
  - detecting or preventing healthcare fraud and abuse
- **Appointment Reminders/Treatment Alternatives** – We may use and disclose your PHI to remind you of an appointment for treatment and medical care with us. We may also use or disclose it to give you information about treatment alternatives. We may also use or disclose it for other health-related benefits and services. For example, information on how to stop smoking or lose weight.
- **As Required by Law** – If federal, state, and/or local law requires a use or disclosure of your PHI, we may use or disclose your PHI information. We do this when the use or disclosure complies with the law. The use or disclosure is limited to the requirements of the law. There could be other laws or regulations that conflict. If this happens, we will comply with the more restrictive laws or regulations.
- **Public Health Activities –** We may disclose your PHI to a public health authority to prevent or control disease, injury, or disability. We may disclosure your PHI to the Food and Drug Administration (FDA). We can do this to ensure the quality, safety or effectiveness products or services under the control of the FDA.
- **Victims of Abuse and Neglect** – We may disclose your PHI to a local, state, or federal government authority. This includes social services or a protective services agency authorized by law to have these reports. We will do this if we have a reasonable belief of abuse, neglect or domestic violence.
- **Judicial and Administrative Proceedings** – We may disclose your PHI in judicial and administrative proceedings. We may also disclose it in response to the following:
  - an order of a court
  - administrative tribunal
  - subpoena
  - summons
  - warrant
  - discovery request
  - similar legal request.

- **Law Enforcement** – We may disclose your relevant PHI to law enforcement when required to do so. For example, in response to a:
    - court order
    - court-ordered warrant
    - summons issued by a judicial officer
    - subpoena
    - grand jury subpoena.

  We may also disclose your relevant PHI to identify or locate a suspect, fugitive, material witness, or missing person.
- **Coroners, Medical Examiners and Funeral Directors** – We may disclose your PHI to a coroner or medical examiner. This may be needed, for example, to determine a cause of death. We may also disclose your PHI to funeral directors, as needed, to carry out their duties.
- **Organ, Eye and Tissue Donation** – We may disclose your PHI to organ procurement organizations. We may also disclose your PHI to those who work in procurement, banking or transplantation of:
    - cadaveric organs
    - eyes
    - tissues.
- **Threats to Health and Safety** – We may use or disclose your PHI if we believe, in good faith, that it is needed to prevent or lessen a serious or imminent threat. This includes threats to the health or safety of a person or the public.
- **Specialized Government Functions** – If you are a member of U.S. Armed Forces, we may disclose your PHI as required by military command authorities. We may also disclose your PHI:
    - to authorized federal officials for national security
    - to intelligence activities
    - the Department of State for medical suitability determinations
    - for protective services of the President or other authorized persons.
- **Workers' Compensation** – We may disclose your PHI to comply with laws relating to workers' compensation or other similar programs, established by law. These are programs that provide benefits for work-related injuries or illness without regard to fault.
- **Emergency Situations** – We may disclose your PHI in an emergency situation, or if you are unable to respond or not present. This includes to a family member, close personal friend, authorized disaster relief agency, or any other person you told us about. We will use professional judgment and experience to decide if the disclosure is in your best interests. If it is in your best interest, we will only disclose the PHI that is directly relevant to the person's involvement in your care.
- **Research** – In some cases, we may disclose your PHI to researchers when their clinical research study has been approved. They must have safeguards in place to ensure the privacy and protection of your PHI.

VERBAL AGREEMENT TO USES AND DISCLOSURE YOUR PHI

We can take your verbal agreement to use and disclose your PHI to other people. This includes family members, close personal friends or any other

person you identify. You can object to the use or disclosure of your PHI at the time of the request. You can give us your verbal agreement or objection in advance. You can also give it to us at the time of the use or disclosure. We will limit the use or disclosure of your PHI in these cases. We limit the information to what is directly relevant to that person's involvement in your healthcare treatment or payment.

We can take your verbal agreement or objection to use and disclose your PHI in a disaster situation. We can give it to an authorized disaster relief entity. We will limit the use or disclosure of your PHI in these cases. It will be limited to notifying a family member, personal representative or other person responsible for you care of your location and general condition. You can give us your verbal agreement or objection in advance. You can also give it to us at the time of the use or disclosure of your PHI.

USES AND DISCLOSURES OF YOUR PHI THAT REQUIRE YOUR WRITTEN AUTHORIZATION

We are required to obtain your written authorization to use or disclose your PHI, with few exceptions, for the following reasons:

- **Sale of PHI** – We will request your written approval before we make any disclosure that is deemed a sale of your PHI. A sale of your PHI means we are getting paid for disclosing the PHI in this manner.
- **Marketing** – We will request your written approval to use or disclose your PHI for marketing purposed with limited exceptions. For examples, when we have face-to-face marketing communications with you. Or, when we give promotional gifts of nominal value.
- **Psychotherapy Notes** – We will request your written approval to use or disclose any of you psychotherapy notes that we may have on file with limited exception. For example, for certain treatment, payment or healthcare operation functions.

All other uses and disclosures of your PHI not described in this Notice will be made only with your written approval. You may take back your approval at any time. The request to take back approval must be in writing. Your request to take back approval will go into effect as soon as you request it. There are two cases it won't take effect as soon as you request it. The first case is when we have already taken actions based on past approval. The second case is before we received your written request to stop.

YOUR RIGHTS

The following are your rights concerning your PHI. If you would like to use any of the following rights, please contact us. Our contact information is at the end of this Notice.

- **Right to Request Restrictions** – You have the right to ask for restrictions on the use and disclosure of your PHI for treatment, payment or healthcare operations. You can also ask for disclosures to persons involved in your care or payment of your care. This includes family members or close friends. Your request should state the restrictions you are asking for. It should also say to whom the restriction applies. We are not required to agree to this request. If we agree, we will comply with your restriction request. We will not comply if the information is needed to provide you with emergency treatment. However, we will restrict the use or disclosure of PHI for payment or healthcare operations to a health plan when you have paid for the service or item out of pocket in full.
- **Right to Request Confidential Communications** – You have the right to ask that we communicate with you about your PHI in other ways or locations. This right only applies if the information could endanger you if it is not communicated in other ways

or locations. You do not have to explain the reason for your request. However, you must state that the information could endanger you if the change is not made. We must work with your request if it is reasonable and states the other way or location where you PHI should be delivered.

- **Right to Access and Receive Copy of your PHI** – You have the right, with limited exceptions, to look at or get copies of your PHI contained in a designated record set. You may ask that we give copies in a format other than photocopies. We will use the format you ask for unless we cannot practicably do so. You must ask in writing to get access to your PHI. If we deny your request, we will give you a written explanation. We will tell you if the reasons for the denial can be reviewed. We will also let you know how to ask for a review or if the denial cannot be reviewed.
- **Right to Change your PHI** – You have the right to ask that we change your PHI if you believe it has wrong information. You must ask in writing. You must explain why the information should be changed. We may deny your request for certain reasons. For example, if we did not create the information you want changed and the creator of the PHI is able to perform the change. If we deny your request, we will provide you a written explanation. You may respond with a statement that you disagree with our decision. We will attach your statement to the PHI you ask that we change. If we accept your request to change the information, we will make reasonable efforts to inform others of the change. This includes people you name. We will also make the effort to include the changes in any future disclosures of that information.
- **Right to Receive an Accounting of Disclosures** – You have the right to get a list of times within the last 6 year period in which we or our business associates disclosed your PHI. This does not apply to disclosure for purposes of treatment, payment, healthcare operations, or disclosures you authorized and certain other activities. If you ask for this more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. We will give you more information on our fees at the time of your request.
- **Right to File a Complaint** – If you feel your privacy rights have been violated or that we have violated our own privacy practices, you can file a complaint with us. You can also do this by phone. Use the contact information at the end of this Notice. You can also submit a written complaint to the U.S. Department of Health and Human Services (HHS). See the contact information on the HHS website at www.hhs.gov/ocr. If you request, we will provide you with the address to file a written complaint with HHS. **WE WILL NOT TAKE ANY ACTION AGAINST YOU FOR FILING A COMPLAINT.**
- **Right to Receive a Copy of this Notice** – You may ask for a copy of our Notice at any time. Use the contact information listed at the end of the Notice. If you get this Notice on our website or by email, you can request a paper copy of the Notice.

CONTACT INFORMATION

If you have any questions about this Notice, our privacy practices related to your PHI or how to exercise your rights you can contact us in writing. You can also contact us by phone. Use the contact information listed below.

Arkansas Total Care
Attn: Privacy Official
8325 Lenexa Drive
Lenexa, KS 66214

1-866-282-6280 (TDD/TTY: 711) Toll Free Phone Number
(TDD/TTY Number) 1-888-282-6428

Non-Discrimination Notice

Arkansas Total Care complies with applicable federal civil rights laws and does not discriminate on the basis of:

- Race
- Color
- National origin
- Age
- Disability, or
- Sex.

Arkansas Total Care does not exclude people or treat them differently because of:

- Race
- Color
- National origin
- Age
- Disability, or
- Sex.

Arkansas Total Care:

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

If you need these services, contact Arkansas Total Care's Customer Service at: 1-866-282-6280 (TDD/TTY: 711)

If you believe that Arkansas Total Care has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Arkansas Total Care Quality Department, Arkansas Total Care, P.O. Box 25010, Little Rock, Arkansas 72221, 1-866-282-6280 or TDD/TTY: 711.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance Arkansas Total Care is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human

Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201
1-800–368–1019, (TDD: 1-800–537–7697).

Language Assistance

Spanish:

Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Arkansas Total Care tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-866-282-6280 or TDD/TTY: 711.

Vietnamese:

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Arkansas Total Care, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-866-282-6280 or TDD/TTY: 711.

Marshallese:

Ñe kwe, ak bar juon eo kwōj jipañe, ewōr an kajjitōk kōn Arkansas Total Care, ewōr aṃ jimwe in bōk jipañ im melele ko ilo kajin eo aṃ ejjeļọk wōņāān. Ñan kōnono ippān juon ri-ukōk, kirlọk 1-866-282-6280 TDD/TTY: 711.

Chinese:

如果您，或是您正在協助的對象，有關於 Arkansas Total Care 方面的問題，您有權利免費以您的母語得到幫助和訊息。如果要與一位翻譯員講話，請撥電話1-866-282-6280 or TDD/TTY: 711.

Laotian:

ຖ ້າທ ່ານ ຫ ຼ ືຄ ົນທ ູ່ທ ່ານກ ໍາລ ັງຊ ່ວຍເຫ ຼ ືອ ມ ຄ ໍາຖາມກ ່ຽວກ ັບ Arkansas Total Care, ທ ່ານມ ສ ິດທ ່ຈະໄດ ້ຮ ັບການຊ ່ວຍເຫ ຼ ືອແລະຂ ໍ້ມູນຂ ່າວສານທ ່ເປ ັນພາສາຂອງທ ່ານ ໂດຍບ ໍ່ມ ຄ ່າໃຊ ້ຈ ່າຍ. ເພ ຼ ືອຈະເວ ົ້າກ ັບນາຍພາສາ ໃຫ ້ໂທຫາ 1-866-282-6280 or TDD/TTY: 711.

Tagalog:

Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Arkansas Total Care, may karapatan ka na makakuha nang tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-866-282-6280 or TDD/TTY: 711.

Arabic:

إذا كان لديك أو لدى شخص تساعده أسئلة حول Arkansas Total Care ، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل ب

1-866-282-6280 or TDD/TTY: 711.

German:

Falls Sie oder jemand, dem Sie helfen, Fragen zu Arkansas Total Care hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-866-282-6280 or TDD/TTY: 711.

French:

Si vous-même ou une personne que vous aidez avez des questions à propos Arkansas Total Care, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-866-282-6280 or TDD/TTY: 711.

Hmong:

Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog Arkansas Total Care, koj muaj cai kom lawv muab cov ntshiab lus qhia uas tau muab sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau 1-866-282-6280 or TDD/TTY: 711.

Korean:

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Arkansas Total Care 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는1-866-282-6280 or TDD/TTY: 711 로 전화하십시오.

Portuguese:

Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Arkansas Total Care, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-866-282-6280 or TDD/TTY: 711.

Japanese:

Arkansas Total Care について何かご質問がございましたらご連絡ください。ご希望の言語によるサポートや情報を無料でご提供いたします。通訳が必要な場合は、1-866-282-6280 or TDD/TTY: 711 までお電話ください。

Hindi:

आप या जिसकी आप मदद कर रहे हैं उनके, Arkansas Total Care के बारे में कोई सवाल हों, तो आपको बबना ककसी खर्च के अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। ककसी दुभाषषये से बात करने के ललए 1-866-282-6280 or TDD/TTY: 711 पर कॉल करें।

Gujarati:

જે તમને અથવા તમે જેમની મદદ કરી રહ્યા હોય તેમને Arkansas Total Care વવશે કોઈ પ્રશ્ન હોય તો તમને, કોઈ ખર્ચ વવના તમારી ભાષામાાં મદદ અને માહહતી પ્રાપ્ત કરવાનો અવકિાર છે. દુભાવષયા સાથે વાત કરવા માટે 1-866-282-6280 or TDD/TTY: 711

arkansas total care™

Glossary

ARTC Member ID card: Identification card – a card that identifies you as an ARTC member.

Advance Directive: Anything you tell people about what you want for your healthcare in the event you are not able to tell them yourself. A living will is the most common advance directive with your PCP.

Appeal: A request to review a Notice of Action. A Notice of Action (NOA) is sent to a member when ARTC denies the care you want, decreases the amount of care, ends care that has already been approved by us in the past, or denies payment for care.

Authorization: A decision to approve special care or other medically necessary care. An authorization can also be called a "referral."

Behavioral Health Services: Mental Health and Substance Use Disorder Services.

Benefits/Covered Services: Services, procedures and medications that ARTC will cover for you when medically necessary.

Carved-out benefits: Services that are not covered by ARTC. Benefits are covered directly by Medicaid.

Continuity and Coordination of Care: Healthcare provided on a continuous basis beginning with the patient's initial contact with a PCP and following the patient through all episodes. Care that is uninterrupted.

Covered Services: Medically necessary services that ARTC will pay the provider for you to receive.

Disenrollment: To stop your membership in ARTC.

Eligible(s): A person whom has been determined eligible to receive services as provided for in the State Medicaid Plan.

Emergency care: When you have an injury or illness that must be treated immediately or is life threatening.

EPSDT/ Well Child Program: Early and Periodic Screening, Diagnosis and Treatment, provides exams for children through the month of their 21st birthday.

Grievance: An expression of dissatisfaction about any matter other than an action.

Home healthcare: Full range of medical and other health-related services that are delivered in the home of a medically home bound patient by a healthcare professional.

In-Network Provider: The group of doctors, hospitals, and other health care providers that ARTC contracts with to provide services. You can find all of our providers at ArkansasTotalCare.com.

Immunizations: Necessary shots to protect your child from life threatening diseases.

Inpatient: When you are admitted into a hospital.

Medicaid: The medical assistance program authorized by Title XIX of the Social Security Act.

Medicaid ID card: Identification card – a card that identifies you as part of the Arkansas Medicaid program. If you are an ARTC member, your ID card will be issued by Arkansas Total Care.

Medical Necessity: This means that a health intervention is an otherwise covered category of service, is not specifically excluded from coverage, and is medically necessary, according to all of the following criteria:

a. ***"Authority"***. The health intervention is

recommended by the treating physician and is determined to be necessary by the secretary or the secretary's designee.

b. ***"Purpose"***. The health intervention has the purpose of treating a medical condition.

c. ***"Scope"***. The health intervention provides the most appropriate supply or level of service, considering potential benefits and harms to the patient.

d. ***"Evidence"***. The health intervention is known to be effective in improving health outcomes. For new interventions, effectiveness shall be determined by scientific evidence as provided herein. For existing interventions, effectiveness shall be determined as provided in paragraph 67.i.

e. ***"Value"***. The health intervention is cost-effective for this condition compared to alternative interventions, including no intervention. "Cost-effective" shall not necessarily be construed to mean lowest price. An intervention may be medically indicated and yet not be a covered benefit or meet this regulation's definition of medical necessity.

f. Interventions that do not meet this regulation's definition of medical necessity may be covered at the choice of the secretary or the secretary's designee. An intervention shall be considered cost effective if the benefits and harms relative to costs represent an economically efficient use of resources for patients with this condition. In the application of this criterion to an individual case, the characteristics of the individual patient shall be determinative.

g. The following definitions shall apply to these terms only as they are used in this subsection 67.;
   1) ***"Effective"*** means that the intervention can be reasonably expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.

Member: A person who is eligible to receive covered services from ARTC as defined by the State of Arkansas.

Notice of Action: written document that includes action planned, reason for planned action, policy, regulation or statute supporting action; explains member rights to expedited or standard appeal, State Fair Hearing; how to request those, and how to request continued services during appeal or State Fair Hearing

Out-of-Network Provider: a health care professional, hospital, or pharmacy that is not part of ARTC's network of contracted providers. You may have to pay for services received from an out-of-network provider.

Outpatient: When you have a procedure done that does not require admission into a hospital.

Preferred Drug List (PDL): A list of medications covered by Medicaid and the Medicaid program.

Prescription Drugs: Any medication that cannot be purchased over the counter and must have written request from your doctor for you to have it.

Prior approval: When ARTC has received, reviewed and approved prior to services being rendered to the Member.

Protected Health Information (PHI): Health information that identifies an individual.

Provider: A physician, hospital or any other person licensed or authorized to provide healthcare services.

Provider Directory: A list of providers participating with ARTC.

Primary Care Provider (PCP): The provider who serves as the entry point into the healthcare system for the member. The PCP provides primary care, coordination and monitoring of referrals to specialist care, authorized hospital services and maintains the

continuity of care.

Referral: The process by which the member's PCP directs him/her to seek and obtain medically necessary, covered services from another healthcare professional.

Self-Referred Services: Services that you do not need to see your PCP for a referral.

Specialist: A doctor that has specific detailed training in one certain medical field.

Termination: The member's loss of eligibility for the Arkansas Medicaid program (Medicaid) and therefore automatic disenrollment from ARTC.

Title XIX: The provisions of Title 42 United States Code Annotated Section 1396 et. seq. (The Social Security Act), including any amendments thereto. Title XIX provides medical assistance for certain individuals and families with low incomes and resources.

Title XXI: The provisions of the Social Security Act as amended in August, 1997 to add Title XXI (known at the federal level as the Children's Health Insurance Program (CHIP), which provides health insurance coverage to uninsured children from low-income families, who are not Title XIX eligible.

Treatment: The care that you may receive from doctors and facilities.

Urgent care: When you have an injury or illness that must be treated within 24 hours. It is not life threatening.

‹Insert Release of Information form›