Welcome to the
community.

Arizona – October 2017

Long Term Care Member Handbook

UnitedHealthcare Community Plan is a Medicaid Long Term Care Plan; covered services are funded under contract with AHCCCS.

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UnitedHealthcare®
Community Plan

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Important Information

Member Services . . . . . **1-800-293-3740, TTY 711**

Monday – Friday, 8:00 a.m. – 5:00 p.m. Arizona time.

After-hours . . . . . **1-800-377-2055, option 1**

In Case of Emergency Dial 911

My ALTCS ID# is: _____

My Case Manager's name is: _____

My Case Manager's phone number is: _____

My Doctor's name is: _____

My Doctor's phone number is: _____

My numbers for non-emergency transportation are:

Medical Transportation Brokerage of Arizona (MTBA)

Reservation line: . . . . . **1-888-700-6822, TTY 711**

(Call this number for a ride)

Reservations should be made Monday – Friday, from 8:00 a.m. to 5:00 p.m. local time. Please call at least 3 business days (excluding weekends and holidays) in advance to make a reservation, but not more than 2 weeks before your scheduled appointment.

Members may also reach medical management, prior authorization and information on dental providers by calling . . . . . **1-800-293-3740, TTY 711**

Revised October 2017

UnitedHealthcare Community Plan • 1 E. Washington, Suite 800 • Phoenix, AZ 85004

Welcome to

UnitedHealthcare Community Plan

We are glad to have you as a member. We look forward to serving your health care needs. UnitedHealthcare Community Plan is a managed care organization. That means all of the medical care and services members receive must be requested and provided by a doctor or health provider who is an AHCCCS registered provider.

UnitedHealthcare Community Plan is a contractor for the Arizona Long Term Care System (ALTCS).

This Member Handbook will help you find services, understand how managed care works, and provide you with valuable resources.

ALTCS.
ALTCS is the same as Medicaid. It was created by the Arizona Health Care Cost Containment System Administration (AHCCCSA) to provide quality long-term care for eligible people in Arizona who cannot pay for certain health related services.

Member Services

Member Services is here to help you with questions. They can tell you about:

- Your membership.
- UnitedHealthcare Community Plan services.
- How to change your doctor (PCP).
- What a complaint is.
- How to contact your Case Manager.
- Help answer other questions you may have.

Member Services can give you material on:

- Living with a chronic illness.
- Preventing falls in your home.
- Eating healthy foods.
- How to get behavioral health care.

You can get a free copy of the member handbook by contacting Member Services, Monday through Friday, 8:00 a.m. to 5:00 p.m., at **1-800-293-3740**, **TTY 711**.

Visit Our Website — UHCCommunityPlan.com

It has resources and helpful information. For example:

- Information about UnitedHealthcare Community Plan.
- Member items such as an electronic copy of the Member Handbook and our newsletters.
- How to contact us.
- Links to other plans by UnitedHealthcare Community Plan.
- Links to the AHCCCS website.
- How to find a doctor.
- How to find a pharmacy.
- How to find a prescription drug.
- How to enroll.
- How to file an appeal or grievance.
- Frequently asked questions.
- Links to health information.
- Member education.
- Survey results.
- Links to your benefit information, or visit directly: **myuhc.com/communityplan**.

What Is a Case Manager and How to Contact Your Case Manager

A Case Manager is a person who helps you set up and schedule your care.
You will get a Case Manager when you enroll. He or she will contact you within 7 business days of your enrollment.

Your Case Manager cannot give you medical care. You go to your doctor or a nurse for medical care. Your Case Manager will help set up services for you and send you for services. Your Case Manager will help you with any behavioral health, medical or social service needs. He or she will also help you to meet your personal goals — this is called Member Empowerment.

Write your Case Manager's name and phone number on the inside cover of this handbook.

How to contact your Case Manager.
Your Case Manager will provide you with their business card that has contact numbers for the Case Manager and UnitedHealthcare Community Plan Member Services. Your Case Manager will review this information with you each time they visit you. Please call your Case Manager if you have any needs or questions between your visits with your Case Manager. If you do not have your Case Manager's telephone number, please call **1-800-293-3740**, **TTY 711**. The call center representative will help you to contact your Case Manager.

After-Hours Care/Urgent Care

If it is not an emergency but your PCP is not available, you can get services at an urgent care center.

If you are not sure your symptoms are life-threatening:

- Contact NurseLine at **1-877-440-0255 (TTY 1-800-855-2880)** available 24 hours per day.
- Call your PCP.
- Call your Case Manager.

See the provider directory for a listing of in-network urgent care centers.

Behavioral Health Crisis Services

If you have a psychiatric EMERGENCY that does not require calling 911, you can use the community crisis system.

Maricopa County	
EMPACT for Mobile Crisis	480-784-1500
Mercy Maricopa Integrated Care	602-222-9444 1-800-631-1314 Toll-Free 1-800-327-9254 TTY – Hearing Impaired
Pima, Santa Cruz, Yuma, La Paz, Pinal and Gila Counties	
Cenpatico Integrated Care	1-866-495-6735 Toll-Free 1-877-613-2076 TTY – Hearing Impaired
Coconino, Mohave, Apache, Navajo and Yavapai Counties	
Health Choice Integrated Care	1-877-756-4090 Toll-Free 1-800-367-8939 TTY – Hearing Impaired

Culturally Competent Services, Materials in Alternative Formats and Interpretation Services

Culturally competent care is having knowledge and skills for positive outcomes. This includes language, lifestyles, values, beliefs and attitudes. Ask for culturally sensitive, translated materials or printed materials in alternative formats to be provided at no cost to you. Contact your Case Manager or Member Services at **1-800-293-3740**, **TTY 711**.

Auxiliary Aids are services or devices help people with impaired sensory, manual, or speaking skills to have an equal opportunity to participate in the health plan. They are provided at no cost to you upon request. These alternative formats include: materials with large print, materials in other languages, and materials in audio or electronic formats. Call your Case Manager or Member Services at **1-800-293-3740**, **TTY 711**.

If English is not your main language, we can provide you with an interpreter at no cost to you. Call your Case Manager or Member Services at **1-800-293-3740**, **TTY 711**.

If you are deaf or hard of hearing, we can provide you with an American Sign Language interpreter at no cost to you. Call your Case Manager or Member Services at **1-800-293-3740**, **TTY 711**.

To find a provider who speaks languages other than English, see the Provider Network section below for more details.

Provider Network

A provider network is a group of providers who contract with UnitedHealthcare Community Plan to provide services. Your Case Manager will help you choose providers from within its provider network. If you'd like to select a provider based on convenience, location or cultural preference, you can tell your Case Manager.

Members can find additional information on a network provider for the following:

- Cultural and linguistic capabilities, including languages offered by the provider or a skilled medical interpreter at the provider's office.
- Offices that accommodate members with physical disabilities by using the UnitedHealthcare Community Plan Provider Directory online at **UHCCommunityPlan.com**.

Members can also use the Doctor Lookup feature online which is a provider search tool to find a doctor, hospital, other health care provider or facility. The tool allows you to search by specific categories. Members can follow this link directly to the Doctor Lookup feature: **http://www.americhoice.com/find_doctor/first.jsp?xplan=uhcaz&xtitle=Doctor#find-a-provider**.

Members can receive a paper copy of the provider directory, at no cost, by contacting their Case Manager or calling Member Services at **1-800-379-2740**, **TTY 711**.

The Counties We Serve

UnitedHealthcare Community Plan is a Contractor for the Arizona Long Term Care System (ALTCS). We serve Apache, Coconino, Gila, Maricopa, Mohave, Navajo, Pinal, and Yavapai counties.

How Managed Care Works

You, your doctor and our Case Manager work together on a plan of care. One of the first steps is for our Case Manager to do an assessment with you. The Case Manager will then set up follow-up phone calls and home visits to meet your needs. You are responsible for working with your doctor, known as your PCP. A Primary Care Provider (PCP) is your doctor or nurse. He or she takes care of your medical and clinical treatment. Your PCP can also refer you to a specialist. Your PCP works with you to manage your care. Talk to your PCP about all of your health care needs.

It is important that you have honest and straightforward communication with your PCP and follow your PCP's instructions. Your PCP will be able to identify the services that you need to keep you healthy.

Eligibility Verification

If you have an Arizona driver's license or state-issued ID, AHCCCS will get your picture from the Arizona Department of Transportation Motor Vehicle Division (MVD). When providers pull up the AHCCCS eligibility verification screen, they will see your picture (if available) with your coverage details.

ID Card

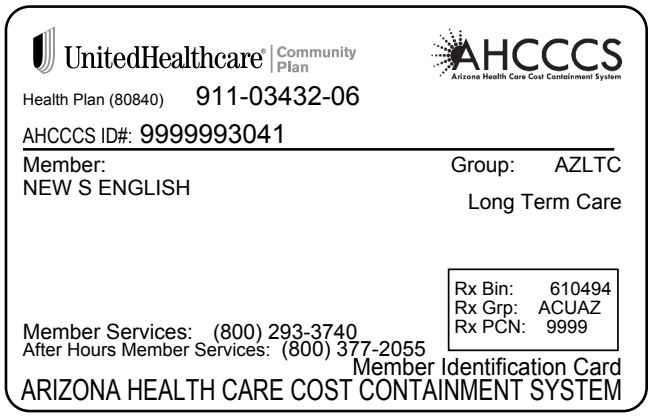
Your ID card will be mailed to the address on your application to ALTCS. If you have not received your card within a few weeks of enrolling, call Member Services at **1-800-293-3740**, **TTY 711** to request a new one.

When you receive your ID card:

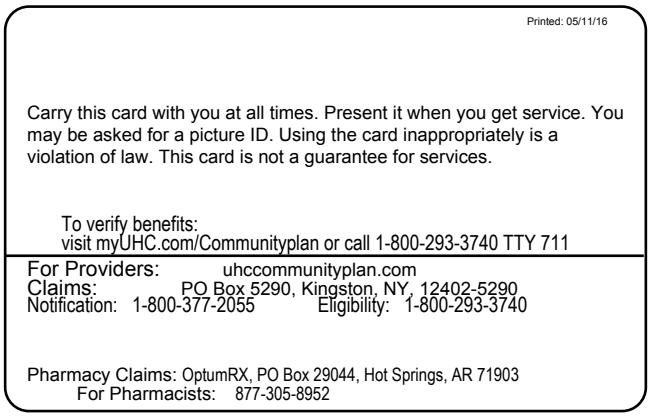
- Check the spelling of your name. If anything is wrong, call Member Services at **1-800-293-3740**, **TTY 711**.
- Always protect your ID card. If it is lost or stolen, call Member Services at **1-800-293-3740**, **TTY 711**.
- If you lose eligibility, the card will be inactive. If you are eligible again or change plans, a new card will be mailed to you.
- Misuse of your card, including loaning, selling or giving it to others could result in loss of your eligibility and/or legal action.

DO NOT THROW AWAY YOUR ID CARD.

Sample card.



Front



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Member Responsibilities

You have the responsibility to:

Use services.

- Ask questions if you do not understand your rights or plan of treatment.
- Keep your appointments.
- Cancel appointments in advance when you cannot keep them.
- Contact your PCP first for non-emergency medical needs.
- Get approval from your PCP before going to a specialist.
- Understand when you should and should not go to an emergency room.
- Know whom to call if you need a ride to the doctor or for other covered services.
- Treat providers and health plan staff with respect and dignity.

Give information.

- Tell your PCP and Case Manager about your health and changes in your health.
- Tell Member Services and/or your Case Manager about changes in your Medicare, Medicare HMO or private insurance. This includes adding or ending other insurance.
- Talk to your providers and your Case Manager about your health care. Ask questions about the ways your health problems can be treated.
- Notify your Case Manager and AHCCCS if your family size changes, if you move or if your income changes.

Follow instructions.

- Work as a team with your PCP and Case Manager to decide what care is best for you.
- Understand how what you do can affect your health.
- Do the best you can to stay healthy.
- Treat providers and staff with respect.

Moving Out of the County, State, or Country

Call your Case Manager before you move to another county, state, or country.

If you move to a county that is NOT served by UnitedHealthcare Community Plan, you will need to change your health plan. Your change must be put in writing and given to your Case Manager. UnitedHealthcare Community Plan will send the request to the new health plan in that area.

If you move out of the state or country, you must sign a disenrollment form. No services are available outside of the United States. This form says you will no longer be a member in the ALTCS program and UnitedHealthcare Community Plan.

If you are briefly away from Arizona or out of your county of residence, you may only get emergency services. Before leaving Arizona or the county, report your absence or trip to your Case Manager.

Changing Plans

You can change your program contractor (Plan):

- Medical continuity of care.* Your continuity of care when changing plans is very important. It is a process that involves you, your PCP, your case manager and all members of your health care team.
- If you get information about available providers that is not correct.*
- If you were not given a choice by ALTCS when you enrolled.*
- During annual open enrollment.*
- If you and a family member are with different Plans.*
- If we end a contract with the facility/setting in which you live.*
- If you move to a county where we are not the ALTCS provider, then your Case Manager will ask for the Plan change on your behalf. He or she will ask that the ALTCS provider for that county accept you.
- If you lost ALTCS eligibility and were disenrolled, then later reapproved for ALTCS eligibility within 90 days of the disenrollment date, but you were enrolled with a different plan.

**Applies only if you reside in Maricopa, Pinal, Gila and Pima counties.*

Contact your Case Manager to ask for a program contractor change request if you desire to change plans.

If your request is for medical continuity of care, Medical Directors of both Plans must agree the change is needed. If not, your request will be denied. If your request is denied, you will be told of the denial. You have the right to appeal.

If you live in Maricopa, Gila, Pinal or Pima counties, once a year AHCCCS will send you information on how to change your plan. This is called open enrollment.

ALTCS Transitional Program

A transitional program is for members who no longer need a nursing home, but may need other long term care services. ALTCS Transitional members whose condition briefly gets worse may get up to 90 continuous days of medically necessary nursing home care at a time.

Even if nursing home care is not medically needed, a short-term stay may be possible using our respite benefit which is an ALTCS home and community-based service.

The transitional program applies only to existing members, not newly enrolled members.

Transition of Care if You Change Plans

If you change plans for any reason, your current health plan and new health plan will work together to make sure you have no delay in services and have continued access to care in services.

Medical Emergency

A medical emergency is sudden with serious symptoms. Without immediate attention, an emergency could place your health in serious danger. Minor problems like a cold, rash, or small cuts and bruises are usually not an emergency. They can usually be treated by seeing your doctor. You and your Case Manager should discuss them and schedule necessary PCP appointments.

In the case of an emergency, call 9-1-1.

If one of these things happens, call **9-1-1** or go to the nearest emergency room **immediately**:

- Danger of losing life or limb.
- Chest pain.
- Poisoning or overdose of medicine or drugs.
- Choking or problems breathing.
- Heavy bleeding.
- Fainting.
- Loss of speech.
- Unconsciousness.
- Car accident.
- Suddenly not being able to move.
- Assault.

You may go to any hospital emergency room (ER) or other setting for emergency care (in or out of network). Show ALL your ID cards when you arrive. If you go to the ER, let your PCP and Case Manager know **within 2 days/48 hours, or as soon as possible**. Emergency care does not need an authorization. **Any follow-up care will be given by your PCP.** You should see your PCP within 7 days after you leave the hospital.

If you get emergency services, ask the hospital or doctor to send your records to your PCP. Call UnitedHealthcare Community Plan if you get emergency services. Show your ALTCS ID card. If you go to an emergency room, tell them:

- You are on ALTCS.
- Your health plan is UnitedHealthcare Community Plan.
- To send your medical records to your PCP.

If you cannot do this yourself, have a friend or family member do this.

Emergency Transportation

Emergency care and transport is available 24 hours a day, 7 days a week. Call **9-1-1** or your local emergency number.

As soon as you are able, **call your PCP and your Case Manager**. If you cannot call, have a friend or family member call. If you live in a nursing or an assisted living facility, let staff know. They will arrange for emergency care and transport for you.

Transportation (Non-Emergency)

You may need to go to your doctor's office but do not have a ride. Your Case Manager will help you get a ride. Or you can call **Medical Transportation Brokerage of Arizona (MTBA)** directly. Call **MTBA** to set up rides for non-emergency medical transport.

Medical Transportation Brokerage of Arizona (MTBA).

Reservation Line: 1-888-700-6822, TTY 711	Call this number for a ride.
Transportation Help Line: 1-888-700-6822, TTY 711	Call this number if your ride is late.

Scheduling Rides

- Requests for health care rides must be made Monday to Friday, 8:00 a.m. to 5:00 p.m. (Arizona time).
- A ride home from medical appointments is available 24 hours per day, 7 days a week.
- You need to call this number at least 3 business days (excluding weekends and holidays) in advance to make a reservation. This gives MTBA time to arrange it. Do not call more than 2 weeks before your appointment.

Your Case Manager will help you. If you have questions, call him or her. You may also call Member Services at **1-800-293-3740**, **TTY 711**.

Your ride will drop you off no earlier than one hour before your appointment. You should not have to wait more than an hour to see your doctor. You should not have to wait more than one hour after your call for a ride home.

Canceling transportation.
If your needs change, call as soon as possible to cancel your transportation.

Covered Services

Your health care services must be from a health care professional who works with AHCCCS and UnitedHealthcare Community Plan. Some services need approval by us before you can get care. The provider must get the approval. This is called Prior Authorization. You do not have to pay for services covered by UnitedHealthcare Community Plan.

UnitedHealthcare Community Plan only covers services that will help you get better. This is called medically needed or medically necessary. It is important to AHCCCS that you get the least costly services that give you the same result. This is called cost-effective. Covered services include, but are not limited to:

- Hearing exams to evaluate medically necessary hearing loss, both inpatient and outpatient.
- Breast reconstruction after a mastectomy.
- Chiropractic services for members under the age of 21.
- Cochlear implants for members under the age of 21.
- Hospital inpatient or outpatient.
- Ambulatory surgery.
- Emergency services, 24-hour emergency care, emergency transport, and emergency room. (Emergency service does not require a prior authorization.)
- Doctor services.
- Services in a Rural Health Clinic or Federally Qualified Health Center.
- Lab, X-rays, and medical imaging.
- Pharmacy services. Members must get drugs from the UnitedHealthcare Community Plan Formulary. This is a list of medicines that UnitedHealthcare Community Plan will provide. Go to **UHCCommunityPlan.com** to view it. Or call your Case Manager. Coverage may include certain Part D excluded drugs, if you are in a Medicare Part D Plan (PDP).
- Most medical supplies and durable medical equipment such as wheelchairs, walkers, oxygen, etc.
- Medically required transport for emergent and non-emergent trips are covered when needed. Call your Case Manager about the different types of transportation services.
- Family planning. This includes birth control pills, supplies and devices; surgical procedures to cause sterility (inability to reproduce), delay or prevent pregnancy.
- Maternity services, including prenatal care, labor and delivery, and postnatal care. Female members may have direct access to OB/GYN providers in the network without a referral.
- Gynecology. Female members have direct access to a gynecologist within the Contractor's network without a referral from a primary care provider. Preventive services such as cervical cancer screening or referral for a mammogram are covered.

- HIV testing and counseling.
- Therapies including: occupational, physical, respiratory (breathing), auditory (hearing), and speech.
- Occupational, physical and speech therapy are covered in inpatient hospital (or nursing facility) or in outpatient settings.
- AHCCCS covers medically necessary foot and ankle care, including reconstructive surgeries, provided by a licensed podiatrist or other qualified licensed practitioner or physician when ordered by a member's primary care physician or primary care practitioner.
- Dialysis services.
- Private duty nurse, if medically necessary.
- Special care for children.
- Preventive services including, but not limited to, screening services such as cervical cancer screening including Pap smear (annually for sexually active women), mammograms (annually after age 40 and at any age if considered medically necessary), colorectal cancer, and screening for sexually transmitted infections.
- Medically required transplants of some organs.
  - Transplant services must be pre-authorized.
  - Transplants must be done at an AHCCCS approved transplant center.
- Treatment of medical conditions of the eye, excluding eye exams for glasses or contact lenses and the glasses or contact lenses, except after cataract surgery, for members who are age 21 or older.
- For members who are 21 years of age and older, emergency care for eye conditions which meet the definition of an emergency medical condition. In addition cataract removal, and medically necessary vision examinations, prescriptive lenses and frames are covered if required following cataract removal.
- Eye exams for glasses or contact lenses and glasses or contact lenses for members under age 21.
- Routine and emergency dental care for members under the age of 21.
- Services previously covered by Children's Rehabilitative Services.
- Metabolic medical foods.
- Well visits (well exams) such as, but not limited to, well-woman exams, breast exams, and prostate exams are covered for members 21 years of age and older. Most well visits (also called checkup or physical) include a medical history, physical exam, health screenings, health counseling and medically necessary immunizations (see EPSDT for well exams for members under 21 years of age).
- Limited medical and surgical services by a dentist for members 21 years of age and older.
- Emergency dental services for members 21 years of age and older. Services are limited to a total amount of $1,000 for each 12-month period beginning October 1 through September 30 each year.

- Dental adult benefits for members who are 21 years of age and older. Dental services are limited to a total amount of $1,000 for each 12-month period beginning October 1 through September 30 each year. Covered services include dentures, and preventive dental care (checkups, cleaning, X-rays if needed, fluoride treatments). You may also have benefits to fix your teeth like fillings, root canals, simple extractions, crowns, or other dental work. If you need major dental work, your dentist may have to check with the plan first to make sure it will all be covered.
- Incontinence briefs — Incontinence briefs are covered for members 21 years of age and older when needed to treat a medical condition like a rash or infection. These briefs are also called adult diapers and pull-ups. Prior approval may be needed. Briefs are also covered to avoid or prevent skin breakdown for **members in the ALTCS program who are 21 years of age and older when**:
  - You have a medical condition which causes incontinence. This is when the body is not able to control going to the bathroom, and
  - The doctor gives you a prescription for the briefs, and
  - No more than 180 briefs are needed in a month, unless the doctor shows that more than 180 briefs in a month are needed, and
  - You get the briefs from the Health Plan's providers, and
  - The doctor has gotten any needed approval from the Health Plan.
- Orthotic devices — Orthotics are devices that help a weak or deformed part of the body.
  - For members under the age of 21, orthotics are covered when prescribed by the member's Primary Care Provider, attending physician, or practitioner.
  - For members age 21 and older, orthotic devices are covered when:
    - The orthotic is medically necessary as the preferred treatment based on Medicare Guidelines, AND
    - The orthotic costs less than all other treatments for the same condition, AND
    - The orthotic is ordered by a doctor or Primary Care Practitioner (a nurse practitioner or physician assistant).
- Hospital observation.
- Hysterectomy (medically necessary).

Behavioral health covered services.

- Behavioral health — individual, group and family therapy and counseling.
- Behavioral health (personal care, family/support/home care training, peer support).
- Behavioral health inpatient facilities.
- Behavioral health laboratory and radiology services for psychotropic medication regulation and diagnosis.
- Behavioral health partial care (supervised day program, therapeutic day program and medical day program).
- Psychosocial rehabilitation (living skills training; health promotion; supportive employment services).
- Substance abuse. Alcohol and/or drug services — outpatient treatment.
- Emergency and non-emergency transportation.
- Screening for behavioral health services.

Prior period coverage.

You may be eligible for Prior Period Coverage (PPC). PPC is for some members with long term home and community-based services (HCBS), nursing home, or assisted living services in place from when the member applied for ALTCS to when the member became eligible for ALTCS.

During PPC, health care services are looked at by the Case Manager. The Case Manager will see if UnitedHealthcare Community Plan is permitted to pay the provider.

The services must meet three areas to qualify for UnitedHealthcare Community Plan payment:

1. Medically necessary.
2. Cost-effective.
3. Provided by an AHCCCS-registered health care provider.

Covered Long Term Care Services – Institutional

Certain covered long term care services may include:

- Nursing home (including Christian Science).
- Institution for mental disease (IMD).
- Psychiatric Residential Treatment Center for age 21 years and under.

Covered Home and Community-Based Services (HCBS)

Covered HCBS Alternative Residential settings may include:

- Assisted Living Home. (ALTCS approved with rooms for 10 or fewer residents.)
- Assisted Living Centers. (A setting that provides resident rooms or residential units and services to 11 or more residents.)
- Adult Foster Care. (ALTCS HCBS approved with services on a continuing basis for four or fewer people.)
- Behavioral Health Residential Facility.
- Traumatic Brain Injury Facility.

Covered Home and Community-Based Services (HCBS) may include:

- Adult day health care.
- Home-delivered meals.
- Home health agency including nursing services and home health aide.
- Emergency Alert System.
- Homemaker services.
- Hospice.
- Personal care.
- Private duty nursing.
- Respite care. Respite care is a temporary break for persons providing care to our members. Respite must be pre-approved and authorized by the Case Manager. 600 respite hours available on an annual basis.
- Group respite as alternative to adult day health.
- Attendant care.
  - Agency with Choice — Allows you to make decisions about the attendant and the schedule you want. Contact your Case Manager for more information.
  - Spouses as paid caregivers authorized by the Case Manager. Contact your Case Manager for more information.
  - Self-directed Attendant Care — Lets you make decisions about the attendant you want. Contact your Case Manager.
- Medically necessary home modifications.
- Supported Employment for Individual or Group.
- Durable Medical Equipment (DME) — Standard and custom DME.

Services Not Covered

These are NOT covered:

- Services from non-AHCCCS providers. (Services given without authorization by a provider who is not with UnitedHealthcare Community Plan.)
- Services that will not help you get better. (Services that are not medically necessary.)
- Services defined by AHCCCS as experimental or solely for research; services for which there is no scientific or medical proof that it will help you. (Experimental services.)
- Services that are not the least costly service with the same result.
- Services that are not cost-effective.
- Hearing aids, eye exams for glasses/lenses, except post-cataract surgery, for members 21 years and over.
- Sex change/gender reassignment operations.
- Reversal of self-requested sterility (typically the inability to reproduce).
- Care not covered under AHCCCS and ALTCS rules or policies.
- Man-made (artificial) hearts or xenografts (taking and transferring tissue from another species/animal).
- Organ transplants not included in AHCCCS rules or policies.
- Services in a place not Medicare/Medicaid certified for such services.
- Room and board in assisted living facilities and behavioral health group homes.
- Drugs, or the cost-sharing (coinsurance, deductibles, and copayments), if you are in or eligible for Medicare Part D Plan (PDP). Medicaid Coverage includes certain Part D excluded drugs.

The following services are not covered family planning services:

- Infertility services including diagnostic testing, treatment services or reversal of surgical infertility.
- Pregnancy termination counseling.

In addition, the following services are not covered, or only limited amounts are covered, for adults 21 years and older:

Benefit/Service	Service Description	Service Excluded From Payment
Bone-Anchored Hearing Aid	A hearing aid that is put on a person's bone near the ear by surgery. This is to carry sound.	AHCCCS will not pay for Bone-Anchored Hearing Aid (BAHA). Supplies, equipment maintenance (care of the hearing aid) and repair of any parts will be paid for.
Cochlear Implant	A small device that is put in a person's ear by surgery to help you hear better.	AHCCCS will not pay for cochlear implants. Supplies, equipment maintenance (care of the implant) and repair of any parts will be paid for.
Lower Limb Microprocessor Controlled Joint/ Prosthetic	A device that replaces a missing part of the body and uses a computer to help with the moving of the joint.	AHCCCS will not pay for a lower limb (leg, knee or foot) prosthetic that includes a microprocessor (computer chip) that controls the joint.
Transplants	A transplant is when an organ or blood cells are moved from one person to another.	Approval is based on the medical need and if the transplant is on the "covered" list. Only transplants listed by AHCCCS as covered will be paid for.
Physical Therapy	Exercises taught or provided by a Physical Therapist to make you stronger or help improve movement.	Effective 01/01/2014, outpatient physical therapy for adults is limited to the following: a. 15 visits per contract year for persons age 21 years or older to restore a particular skill or function the individual previously had but lost due to injury or disease and maintain that function once restored; and, b. 15 visits per contract year for persons age 21 years or older to attain or acquire a particular skill or function never learned or acquired and maintain that function once acquired. A "visit" is defined as all physical therapy services received on the same day.

Housing Services

Your Case Manager can assist you in finding local low-income housing that is available utilizing our Program Housing Coordinator.

For members with a Serious Mental Illness (SMI) there are Non-Title 19 services, available based on funding, for: Supported housing services to assist individuals or families to obtain and maintain housing in an independent community setting including the person's own home or apartments and homes owned or leased by a subcontracted provider. These services include rent and/or utility subsidies, and relocation services to a person or family for the purpose of securing and maintaining housing.

Residential Placement

Institutional Placements.
Institution for Mental Diseases (IMD): A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases (including substance use disorders), including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for Individuals with Intellectual Disabilities is not an institution for mental diseases.

Nursing Facility, including Religious Nonmedical Health Care Institutions: The nursing facility must be licensed and Medicare/Medicaid certified by ADHS to provide inpatient room, board and nursing services to members who require these services on a continuous basis but who do not require hospital care or direct daily care from a physician.

Behavioral Health Inpatient Facility: A health care institution that provides continuous treatment to an individual experiencing a behavioral health issue that causes the individual to:

1. Have a limited or reduced ability to meet the individual's basic physical needs,
2. Suffer harm that significantly impairs the individual's judgment, reason, behavior, or capacity to recognize reality,
3. Be a danger to self,
4. Be a danger to others,
5. Be a person with a persistent or acute disability, or
6. Be a person with a grave disability.

Alternative HCBS Placements.
Assisted Living Facility: An Assisted Living Facility (ALF) is a residential care institution that provides supervisory care services, personal care services or directed care services on a continuing basis. All approved residential settings in this category are required to meet ADHS licensing criteria. Covered settings include:

Adult Foster Care Home: An Alternative HCBS Setting that provides room and board, supervision and coordination of necessary adult foster care services within a family type environment for at least one and no more than four adult residents who are ALTCS members.

Assisted Living Home: An Alternative HCBS Setting that provides room and board, supervision and coordination of necessary services to 10 or fewer residents.

Assisted Living Center: An Alternative HCBS Setting, that provides room and board, supervision and coordination of necessary services to more than 11 residents.

Adult Developmental Home: An Alternative HCBS Setting for adults (18 or older) with developmental disabilities which is licensed by DES to provide room, board, supervision and coordination of habilitation and treatment for up to three residents.

Child Developmental Certified Home: An Alternative HCBS Setting for children (under age 18) with developmental disabilities which is licensed by DES and provides room and board, supervision and coordination of habilitation and treatment for up to three residents.

End of Life Care

End of Life (EOL) care is a member-centered approach with the goal of preserving the member's rights and maintain dignity while receiving medically necessary Covered services. End of Life care focuses on health care and supportive services provided at any stage of a illness and provides quality of life for the member. Services can include:

- Palliative Care & Supportive Care.
- Hospice Care.
- Advance Care Planning.

Specialist, Referrals and Self-Referral

A specialist is a health care provider who cares for a certain area of the body.

Your PCP may want you to see a specialist. Your PCP can provide you with an order (referral) to see a UnitedHealthcare Community Plan specialist or make the appointment for you. This includes behavioral health services.

If your PCP wants you to see a specialist who is not contracted with UnitedHealthcare Community Plan:

- The specialist must be registered with AHCCCS.
- Your PCP must get approval from UnitedHealthcare Community Plan.
- This is called a Prior Authorization.

Some specialists, like behavioral health and OB/GYN, do not require the PCP to make the referral. Members can self-refer.

Accessing Services

Case Managers work with you to see which health services you need. These are services to help care for you and keep you safe in places such as your home. The cost must usually be no more than the cost for living in a nursing home.

We want to make sure you are living in the best place for your situation. Case Management makes a plan with you to meet your personal care and medical needs.

If you have questions, contact your Case Manager. He or she will visit you to help with your health care needs. They can help you:

- Pick a doctor (PCP).
- Get care with your doctor.
- Manage medical services.
- Solve problems with your care through goal setting.
- Find ways to live at home.
- Explain service and placement options.
- Help with locating community resources through Member Empowerment (me*) Housing, Education and Employment Program.

UnitedHealthcare Community Plan does not restrict access to services based upon moral or religious principles. This includes counseling or referral services. If a provider refuses to provide services they find objectionable because of moral or religious grounds, we will assist you to get access to another provider who is willing to provide these services. For help, contact your Case Manager or call Member Services at **1-800-379-2740**, **TTY 711**.

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

Choosing a Primary Care Provider (PCP)

As a member of UnitedHealthcare Community Plan, you must choose a PCP. You will need to pick a PCP who is registered with AHCCCS and contracted with UnitedHealthcare Community Plan. Your Case Manager will provide a list of our providers. Picking a PCP is important. If you are in a nursing home, your PCP will visit you there.

If your current PCP is a UnitedHealthcare Community Plan PCP, you do not need to pick a new PCP. If your current PCP does NOT work with UnitedHealthcare Community Plan, your Case Manager will help you pick a new PCP. Refer to the list of UnitedHealthcare Community Plan PCPs. If you do not pick a PCP, one will be assigned to you. We will then inform you of your PCP's name, address and phone number.

For Maternity and Family planning, you should pick a Primary Care OB (obstetrician). The OB ensures you get pre- and postpartum services. These are services before and after your pregnancy.

How Do I Change My PCP?

You can change your PCP.
Usually it is better to stay with the same PCP. Your PCP knows you and has your records and knows what drugs you take. Your PCP is the best person to make sure you get good care. There may be a time you want to change PCPs. If so, call or write your Case Manager. He or she will send you a list of UnitedHealthcare Community Plan providers to pick from. Or you can go to **UHCCommunityPlan.com**. Once you have chosen your new PCP, let your Case Manager know right away. Your PCP change will happen on the first day of the month after we get your written request.

Some reasons you may change your PCP:

- You have moved and need a PCP closer to your home.
- You are not happy with your PCP.

Some reasons you may not change your PCP:

- You asked for a PCP who is not with AHCCCS.
- You asked for a PCP who is not taking new patients.

Your PCP may ask you to change to another PCP if:

- You and your PCP do not get along.
- You do not follow your PCP's advice.
- You are late or do not show up for appointments.

If you lose and regain AHCCCS eligibility within 90 days, you will be re-enrolled with the same PCP, if he or she is still in the plan.

How Do I Make Appointments?

Your PCP and Case Manager will work with you to get the care you need. PCPs are required to provide coverage 24 hours a day, 7 days a week. If you need an immediate or urgent appointment and your PCP is not able to give you one, you may call UnitedHealthcare Community Plan at **1-800-293-3740**, **TTY 711** for help. Try to set up PCP visits as far ahead as possible. Your PCP sees many patients every day. Your PCP visit will occur within the number of days shown below.

If you need help making an appointment, call your Case Manager. If you are in a nursing or assisted living facility, ask the staff to help you; if they cannot, call your Case Manager.

PCP appointments.

Immediate Need:	Same day, or within 24 hours of the member's call or as medically needed.
Urgent Care:	Within 2 days.
Routine Care:	Within 21 days.

Canceling or changing appointments.
Call at least 24 hours in advance of your appointment or as soon as possible to cancel or change appointments (PCP and Specialist). If you miss more than one visit without calling, your doctor may not see you again.

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

How Can I Be Involved in My Health Care?

Be involved in your care by seeing your PCP often. You will take part in choices about your care. We will send you newsletters with helpful information about health care. We will also tell you about new things going on with your plan.

In addition, we may send you surveys about your health and UnitedHealthcare Community Plan. Completing these surveys is another way to take part in your health care.

Take advantage of these materials.
We want you to feel in control of your health and your health care. We have many brochures that can be of help to you. They include:

- **Preventive care** — Preventive Services Reminder, Immunizations, Glaucoma Screenings.
- **Chronic conditions** — Diabetes, Chronic Obstructive Pulmonary Disease, Heart Failure, Coronary Artery Disease, Taking Charge of Blood Pressure, Spinal Stenosis, Dementia, Depression, Dysrhythmia, Peripheral Vascular Disease, Deep Vein Thrombosis and Pulmonary Embolisms, Neuropathic Foot Care.
- **Ways to keep your living area safe.**
- ***You Can Quit Smoking*** brochure.
- **Flu and Pneumonia Vaccination Information** — Signs and Symptoms of the Flu, Caring for the Flu, Flu Guide – Q & A, *No More Excuses* brochure.

To get brochures, contact your Case Manager or call Member Services at 1-800-293-3740, TTY 711.
You also can review your Plan of Care at **myuhc.com/CommunityPlan**.

What Types of Care Are Available for Children?

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

The purpose of EPSDT is to ensure the availability and accessibility of health care resources, as well as to assist Medicaid recipients in effectively utilizing these resources. EPSDT services provide comprehensive health care through primary prevention, early intervention, diagnosis, medically necessary treatment, and follow-up care of physical and behavioral health conditions for AHCCCS members less than 21 years of age.

EPSDT services include screening services, vision services, dental services, hearing services and all other medically necessary mandatory and optional services listed in federal law 42 USC 1396d(a) to correct or ameliorate defects and physical and mental illnesses and conditions identified in an EPSDT screening whether or not the services are covered under the AHCCCS state plan.

Limitations and exclusions, other than the requirement for medical necessity and cost-effectiveness, do not apply to EPSDT services. A well-child visit is synonymous with an EPSDT visit and includes all screenings and services described in the AHCCCS EPSDT and dental periodicity schedules.

Amount, duration and scope.
The Medicaid Act defines EPSDT services to include screening services, vision services, dental services, hearing services and "such other necessary health care, diagnostic services, treatment and other measures described in federal law subsection 42 USC 1396d(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the (AHCCCS) state plan."

This means that EPSDT covered services include services that correct or ameliorate physical and mental defects, conditions, and illnesses discovered by the screening process when those services fall within one of the 29 optional and mandatory categories of "medical assistance" as defined in the Medicaid Act. Services covered under EPSDT include all 29 categories of services in the federal law even when they are not listed as covered services in the AHCCCS state plan, AHCCCS statutes, rules, or policies as long as the services are medically necessary and cost-effective.

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

Female members have direct access to preventive and well-care services from a gynecologist within the contractor's network without a referral from a primary care provider.

Maternity and Postpartum Care

UnitedHealthcare Community Plan gives you comprehensive maternity care. You get maternity care before, during, and after you have your baby. It is important for new mothers to take care of their health before, during, and after their pregnancy. UnitedHealthcare Community Plan has a program called Healthy First Steps for UnitedHealthcare Community Plan members. Healthy First Steps provides information, education and support to help reduce problems while you are pregnant. If you think you may be pregnant or as soon as you know you are pregnant, call Healthy First Steps at 1-800-599-5985. Staying healthy includes follow-up visits with your doctor. Members may have direct access to services from an OB/GYN in the UnitedHealthcare Community Plan network without a referral. Members may select an OB, GYN, or an OB/GYN as a PCP. Prenatal HIV testing and counseling services are available to members. It is important you schedule and keep appointments with your OB/GYN. It is important to follow up with your practitioner after delivery of the baby. This is called postpartum care. It is covered for 60 days post-delivery.

If you had a cesarean section, your doctor may want to see you sooner.

At your postpartum checkup, your doctor will:

- Check to make sure you are healing well.
- Screen you for postpartum depression.
- Do a pelvic exam to make sure reproductive organs are back to pre-pregnancy.
- Answer questions about breastfeeding and examine your breasts.
- Address questions about having sex again and birth control options.

A certified nurse midwife may provide some maternity care. Members who get services from a certified nurse midwife or a licensed midwife must also have a PCP. Licensed midwives may not give any other medical services beyond maternity care within the scope of their practice. Primary care or PCP services are not within this scope.

Let your Case Manager know when you find out you are pregnant. In Maricopa and Pima counties, you may change plans for continuity of care if your OB is with another plan. Contact your Case Manager if you want to switch plans.

You may be able to deliver your baby at home with a certified midwife. If you do not have any risks and would like to have your baby at home, contact your OB or PCP. Let your Case Manager know as well.

Case Managers will refer members for support services from the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), as well as other community resources. WIC services are available to children, birth to age 5. Members who lose eligibility may contact the Arizona Department of Health Services Hotline for referrals to low- or no-cost services.

Maternity care appointment standards.

First Trimester:	Within 14 days of the request.
Second Trimester:	Within 7 days of the request.
Third Trimester:	Within 3 days of the request.
High-Risk Pregnancies:	Within 3 days of identification. Immediately in an emergency.

Family Planning Services

UnitedHealthcare Community Plan offers family planning to both male and female members of reproductive age. Family planning benefits include, but are not limited to: exams, lab tests, birth control, birth control counseling, and HIV testing and counseling. If you have questions, call your Case Manager. Family planning includes the following services:

- Birth Control Pills: Pill taken every day.
- Condom (Rubber).
- Depo Provera: Shot given every 3 months for women.
- Diaphragm: Vaginal removable barrier worn by women.
- Emergency Contraceptive Pill (ECP): Pill taken after unplanned sex to prevent pregnancy.
- Family planning counseling services.
- Family planning lab services.

- IUD: Device placed in the uterus.
- Natural Family Planning.
- Spermicidal Jelly, Cream, or Foam: Vaginal Medication.
- Subcutaneous (under the skin) implantable contraceptives.
- Tubal Ligation: Surgical procedure for women 21 and older.
- Vasectomy: Surgical procedure for men 21 and older.

Members have free choice of providers for family planning. **Family planning services do not require a referral from your PCP.** Contact your Case Manager for help in finding low cost/no cost family planning providers in your area. This is available even after a member has lost AHCCCS coverage. Members can also choose their own family planning provider using the provider directory on our website, or you may choose a provider who is not in our network of providers. If you choose a provider not in our network, the provider will need to obtain prior authorization for services and supplies. The provider must also be registered with AHCCCS.

Medically Necessary Pregnancy Terminations.
Pregnancy terminations are an AHCCCS covered service only in special situations. AHCCCS covers pregnancy termination if one of the following criteria is present:

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

Dental Homes

We feel that dental care is just as important as other care you receive. That's why we assign our members under 21 years of age to a dental home. This is like your Primary Care Physician, but for dental care.

You would see this dentist for your dental care. We send you the name and address of the dental home you're assigned to in the mail. If you want to change your dental home, call **1-800-293-3740**, **TTY 711**. Please call your dentist to schedule an appointment. Members can receive preventive visits two times per year (every six months).

Dental providers can be found on the **UHCCommunityPlan.com** website. Or you can call your Case Manager for help finding a provider and making dental appointments.

Cancelling or changing your dental appointment.
If you need to cancel or change your dental appointment, please call your dental provider at least 24 hours in advance of the appointment. Reschedule your appointment for another time.

Dental referrals.

Immediate Need:	Within 24 hours of the referral.
Urgent Care: For members under 21 years old.	Within 3 days of the referral.
Routine Care: For members under 21 years old.	Within 45 days of the referral.

Getting Your Prescriptions (Drugs)

Getting your prescription drugs is an important part of your health care. Prescription drugs on UnitedHealthcare Community Plan's drug list that are prescribed by your doctor are covered. You can get your prescriptions filled at any UnitedHealthcare Community Plan network pharmacy. Many are available 24 hours a day. For a list of pharmacies, use your provider directory or go to **UHCCommunityPlan.com**. If you have a problem getting your prescription, ask the pharmacy staff to call the prescription benefit manager at 1-877-305-8952 or call your assigned Case Manager.

If you have a problem getting your prescription during normal business hours, call Member Services. If you have a problem getting your prescriptions after normal business hours, on weekends, or holidays, have your pharmacist call the pharmacy help desk. This number is on the back of your ID card.

Prescription Drug Monitoring

UnitedHealthcare Community Plan ensures the member receives the appropriate medication, dosage, quantity and frequency by monitoring prescription patterns by members, providers and pharmacies. The review requirements are to determine the misuse of drugs or over-utilization of drugs.

Pharmacy criteria includes:
Member utilized the following in a 3-month time period:

- 4 or more prescribers; and
- 4 or more different abuse potential drugs; and
- 4 or more Pharmacies.

OR

Member has received 12 or more abuse potential prescriptions in the past 3 months.

OR

Diagnosis of poisoning in 6 months, or "other potential indicators of medication misuse."

Behavioral Health Services

If you need Behavioral Health Services, contact your Case Manager. Behavioral Health Services are available to treat both mental health and substance use disorders. Your Case Manager can help pick a provider. You can also self-refer by calling a provider from the provider directory. Your Case Manager will give you a directory or you can go online at **UHCCommunityPlan.com**.

Your Case Manager can help you understand your behavioral health benefit. Covered Behavioral Health Services include, but may not be limited to, the following:

- Behavior Management (personal care, family support/home care training, peer support).
- Emergency Behavioral Health Care.
- Emergency and Non-Emergency Transportation.
- Individual, Group and Family Therapy and Counseling.
- Inpatient Hospital Services — Behavioral Health Inpatient Facilities.
- Laboratory and Radiology services for Psychotropic Medication regulation and diagnosis.
- Opioid Agonist Treatment.
- Partial Care (supervised day program, therapeutic day program and medical day program).
- Psychosocial Rehabilitation (living skills training; health promotion; supportive employment services).
- Psychotropic Medication.
- Psychotropic Medication Adjustment and Monitoring by a behavioral health professional.
- Respite care — with limits.
- Screening for behavioral health services.

The first behavioral health service after the initial assessment will be within the time frame indicated by the behavioral health condition, but no later than 23 days after the initial assessment. All subsequent behavioral health services will be within the time frame indicated by the behavioral health condition, but no later than 45 days from identification of need.

If you are in behavioral health treatment and need an appointment.
If you need an immediate appointment, call your provider. You will be seen within 24 hours. If it is not an immediate need, your provider can see you within 23 days. Your Case Manager can help you secure an appointment.

If you feel you may harm yourself or others, call 911 for emergency help.

For referrals for psychotropic medications.
The urgency of the need will be assessed immediately. An appointment with a Behavioral Health Medical Professional will be set up within the time frame indicated by clinical need, but no later than 30 days from the identification of need.

For behavioral health appointments for persons in legal custody of the Department of Child Safety (DCS) and adopted children in accordance with A.R.S. §8-512.01:

A. A Rapid Response will be set up when a child enters out-of-home placement within the time frame indicated by the behavioral health condition, but no later than 72 hours after notification by DCS that a child has been or will be removed from their home.
B. Initial Evaluation within seven calendar days after referral or request for behavioral health services. Initial Appointment within time frames indicated, by clinical need, but no later than 21 days after the initial evaluation.
C. Subsequent Behavioral Health Services within the time frames according to the needs of the person, but no longer than 21 days from the identification of need.

Specialized Services for Members Who Have a Serious Mental Illness (SMI)

If you think you have a Serious Mental Illness (SMI) but have not been determined as such, talk to your Case Manager who will assist you.

Members who are already determined to be SMI are eligible for:

- Special Assistance from the Office of Human Rights if you meet the criteria for Special Assistance, and
- Non-Title 19 services, based on the availability of funding, for:
  - Supported housing services to assist individuals or families to obtain and maintain housing in an independent community setting including the person's own home or apartments and homes owned or leased by a subcontracted provider. These services include rent and/or utility subsidies, and relocation services to a person or family for the purpose of securing and maintaining housing.
  - Auricular acupuncture that is medically and clinically necessary. To be performed by a certified acupuncturist practitioner of auricular acupuncture needles to treat alcoholism, substance use or chemical dependency.
  - Traditional Healing Treatment services for mental health or substance use problems provided by qualified traditional healers. These services include the use of techniques aimed to relieve the emotional distress evident by disruption of the person's functional ability.

These services are not a part of covered benefits and are only available as approved by AHCCCS.

Arizona's Vision for the Delivery of Behavioral Health Services

All behavioral health services are delivered according to the following system principles. AHCCCS supports a behavioral health delivery system that includes:

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

The Twelve Principles for the Delivery of Services to Children

1. **Collaboration with the child and family:**
   a. Respect for and active collaboration with the child and parents is the cornerstone to achieving positive behavioral health outcomes, and
   b. Parents and children are treated as partners in the assessment process, and the planning, delivery, and evaluation of behavioral health services, and their preferences are taken seriously.
2. **Functional outcomes:**
   a. Behavioral health services are designed and implemented to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults, and
   b. Implementation of the behavioral health services plan stabilizes the child's condition and minimizes safety risks.
3. **Collaboration with others:**
   a. When children have multi-agency, multi-system involvement, a joint assessment is developed and a jointly established behavioral health services plan is collaboratively implemented,
   b. Client-centered teams plan and deliver services, and
   c. Each child's team includes the child and parents and any foster parents, any individual important in the child's life who is invited to participate by the child or parents. The team also includes all other persons needed to develop an effective plan, including, as appropriate, the child's teacher, the child's DCS and/or DDD caseworker, and the child's probation officer.

d. The team:

i. Develops a common assessment of the child's and family's strengths and needs,

ii. Develops an individualized service plan,

iii. Monitors implementation of the plan, and

iv. Makes adjustments in the plan if it is not succeeding.

4. **Accessible services:**

a. Children have access to a comprehensive array of behavioral health services, sufficient to ensure that they receive the treatment they need,

b. Case management is provided as needed,

c. Behavioral health service plans identify transportation the parents and child need to access behavioral health services, and how transportation assistance will be provided, and

d. Behavioral health services are adapted or created when they are needed but not available.

5. **Best practices:**

a. Behavioral health services are provided by competent individuals who are trained and supervised,

b. Behavioral health services are delivered in accordance with guidelines adopted by ADHS that incorporate evidence-based "best practices,"

c. Behavioral health service plans identify and appropriately address behavioral symptoms that are reactions to death of a family member, abuse or neglect, learning disorders, and other similar traumatic or frightening circumstances, substance abuse problems, the specialized behavioral health needs of children who are developmentally disabled, maladaptive sexual behavior, including abusive conduct and risky behavior, and the need for stability and the need to promote permanency in class members' lives, especially class members in foster care, and

d. Behavioral health services are continuously evaluated and modified if ineffective in achieving desired outcomes.

6. **Most appropriate setting:**

a. Children are provided behavioral health services in their home and community to the extent possible, and

b. Behavioral health services are provided in the most integrated setting appropriate to the child's needs. When provided in a residential setting, the setting is the most integrated and most home-like setting that is appropriate to the child's needs.

7. **Timeliness:**

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

8. **Services tailored to the child and family:**
   a. The unique strengths and needs of children and their families dictate the type, mix, and intensity of behavioral health services provided, and
   b. Parents and children are encouraged and assisted to articulate their own strengths and needs, the goals they are seeking, and what services they think are required to meet these goals.
9. **Stability:**
   a. Behavioral health service plans strive to minimize multiple placements,
   b. Service plans identify whether a class member is at risk of experiencing a placement disruption and, if so, identify the steps to be taken to minimize or eliminate the risk,
   c. Behavioral health service plans anticipate crises that might develop and include specific strategies and services that will be employed if a crisis develops,
   d. In responding to crises, the behavioral health system uses all appropriate behavioral health services to help the child remain at home, minimize placement disruptions, and avoid the inappropriate use of the police and the criminal justice system, and
   e. Behavioral health service plans anticipate and appropriately plan for transitions in children's lives, including transitions to new schools and new placements, and transitions to adult services.
10. **Respect for the child and family's unique cultural heritage:**
    a. Behavioral health services are provided in a manner that respects the cultural tradition and heritage of the child and family, and
    b. Services are provided in Spanish to children and parents whose primary language is Spanish.
11. **Independence:**
    a. Behavioral health services include support and training for parents in meeting their child's behavioral health needs, and support and training for children in self-management, and
    b. Behavioral health service plans identify parents' and children's need for training and support to participate as partners in the assessment process, and in the planning, delivery, and evaluation of services, and provide that such training and support, including transportation assistance, advance discussions, and help with understanding written materials, will be made available.
12. **Connection to natural supports:**
    a. The behavioral health system identifies and appropriately utilizes natural supports available from the child and parents' own network of associates, including friends and neighbors, and from community organizations, including service and religious organizations.

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

1. **Respect.**
   Respect is the cornerstone. Meet the person where they are without judgment, with great patience and compassion.
2. **Persons in recovery choose services and are included in program decisions and program development efforts.**
   A person in recovery has choice and a voice. Their self-determination in driving services, program decisions and program development is made possible, in part, by the ongoing dynamics of education, discussion, and evaluation, thus creating the "informed consumer" and the broadest possible palette from which choice is made. Persons in recovery should be involved at every level of the system, from administration to service delivery.
3. **Focus on individual as a whole person, while including and/or developing natural supports.**
   A person in recovery is held as nothing less than a whole being: capable, competent, and respected for their opinions and choices. As such, focus is given to empowering the greatest possible autonomy and the most natural and well-rounded lifestyle. This includes access to and involvement in the natural supports and social systems customary to an individual's social community.
4. **Empower individuals taking steps toward independence and allowing risk taking without fear of failure.**
   A person in recovery finds independence through exploration, experimentation, evaluation, contemplation and action. An atmosphere is maintained whereby steps toward independence are encouraged and reinforced in a setting where both security and risk are valued as ingredients promoting growth.
5. **Integration, collaboration, and participation with the community of one's choice.**
   A person in recovery is a valued, contributing member of society and, as such, is deserving of and beneficial to the community. Such integration and participation underscores one's role as a vital part of the community, the community dynamic being inextricable from the human experience. Community service and volunteerism is valued.
6. **Partnership between individuals, staff, and family members/natural supports for shared decision making with a foundation of trust.**
   A person in recovery, as with any member of a society, finds strength and support through partnerships. Compassion-based alliances with a focus on recovery optimization bolster self-confidence, expand understanding in all participants, and lead to the creation of optimum protocols and outcomes.

7. **Persons in recovery define their own success.**
   A person in recovery — by their own declaration — discovers success, in part, by quality of life outcomes, which may include an improved sense of well-being, advanced integration into the community, and greater self-determination. Persons in recovery are the experts on themselves, defining their own goals and desired outcomes.
8. **Strengths-based, flexible, responsive services reflective of an individual's cultural preferences.**
   A person in recovery can expect and deserves flexible, timely, and responsive services that are accessible, available, reliable, accountable, and sensitive to cultural values and mores. A person in recovery is the source of his/her own strength and resiliency. Those who serve as supports and facilitators identify, explore, and serve to optimize demonstrated strengths in the individual as tools for generating greater autonomy and effectiveness in life.
9. **Hope is the foundation for the journey toward recovery.**
   A person in recovery has the capacity for hope and thrives best in associations that foster hope. Through hope, a future of possibility enriches the life experience and creates the environment for uncommon and unexpected positive outcomes to be made real. A person in recovery is held as boundless in potential and possibility.

Multi-Specialty Interdisciplinary Clinics

Multi-Specialty Interdisciplinary Clinics (MSICs) are clinics where members under the age of 21 can see their medical specialists and any others involved in their care, all at one location. At the MSIC, you and your family can meet face-to-face with the members of your team of providers to get medical care, plan your treatment, and receive other services that you may need. Each MSIC is open from the hours of 8:00 a.m. to 5:00 p.m. Monday through Friday. Specific clinics, such as the cardiac clinic, may be held on certain days and times. Contact your MSIC for a schedule of clinics. To make, change or cancel appointments at the MSIC, contact the MSIC at the clinic phone number listed below.

Medical providers on your team could be:

Surgeons
General pediatric surgeons
Cardiovascular and thoracic surgeons
Ear, Nose and Throat (ENT) surgeons
Neurosurgeons
Ophthalmology surgeon
Orthopedic surgeons (general, hand, scoliosis, amputee)
Plastic surgeons

Medical Specialists
Cardiologists
Neurologists
Rheumatologists
General Pediatricians
Geneticists
Urologists
Metabolocists

Dental Providers
Dentists
Orthodontists

CRS MSICs are at the following locations:

DMG Children's Rehabilitative Services
3141 North 3rd Avenue
Phoenix, AZ 85013
602-914-1520
855-598-1871

Children's Clinics
Square & Compass Building
2600 North Wyatt Drive
Tucson, AZ 85712
520-324-5437
800-231-8261

Children's Rehabilitative Services
1200 North Beaver
Flagstaff, AZ 86001
928-773-2054
800-232-1018

Children's Rehabilitative Services
2851 South Avenue B
Building 25 #2504
Yuma, AZ 85364
928-336-7095
800-837-7309

Prior Authorization

UnitedHealthcare Community Plan will reply to your PCP's Prior Authorization request no later than 72 hours following the receipt of the authorization request unless an extension is in effect. If it is not urgent, a decision will be made within fourteen (14) calendar days.

Sometimes we need more time to get the records. We may need 14 more days. This is called an extension. For any decision not made within this time, the request will be considered denied on the day the time expires.

If we deny a request, you will get a letter. If we need an extension, you will get a letter. The letter will tell you the reason for the extension or denial. It will tell you your appeal rights. Criteria that decisions are based on are available upon request.

If you have questions, ask your Case Manager or contact Member Services at **1-800-293-3740**, **TTY 711**.

Freedom of choice.
A provider network is a group of providers who contract with UnitedHealthcare Community Plan to provide services. Your Case Manager will help you choose providers from within its provider network. If you'd like to select a provider based on convenience, location or cultural preference, you can tell your Case Manager.

If our provider network is unable to provide medically necessary services required that you need, then these services can be covered through an out-of-network provider until a network provider is contracted.

Members can also choose their own family planning provider using the provider directory on our website, or you may choose a provider who is not in our network of providers.

If you choose a provider not in our network, the provider will need to obtain prior authorization for services.

All out-of-network providers must also be registered with AHCCCS.

Member Share of Cost

People who are enrolled in Arizona Long Term Care System (ALTCS) are not asked to pay copayments. This applies to copayments charged under Medicaid (AHCCCS). It does not mean a person is exempt from Medicare copayments.

Under ALTCS, you may pay for part of the cost of your services. If you have a monthly income, ALTCS will figure how much you need to pay. If you are living in a nursing center, you pay your "share of cost" to the center. ALTCS will tell you your "Member share of cost." You may ask your ALTCS Eligibility Worker for these amounts at any time.

If you live in the community, you may have a share of cost, payable to UnitedHealthcare Community Plan.

If you are in an assisted living facility, you must pay for your room and board. You pay this directly to your facility. Your Case Manager will tell you what your room and board will be.

Can a Provider Bill Me?

I received a bill for medical services, or my doctor wants a copay.
Tell your provider you are an ALTCS member. Show them your ID card. You do not have to pay bills or copays for any service covered by ALTCS from AHCCCS registered providers. The provider is not allowed to bill you. If you do get a bill, call the provider and tell them to stop billing you and to send a claim to UnitedHealthcare Community Plan.

When can members be billed for benefits that are not covered by AHCCCS?
If you agree to receive services that are not covered by UnitedHealthcare Community Plan or agree to receive services that are in excess of what is allowed by the plan, you may have to pay the bill.

AHCCCS rule R9-22-702D lets an AHCCCS provider charge, submit a claim to, or demand or collect payment for services from a member if:

1. The member requests a benefit that is not covered or not authorized by the health plan or AHCCCS; and
2. The provider provides the member with a document describing the benefits and the approximate cost; and
3. The member signs the document prior to getting the benefits, showing that the member understands and accepts responsibility for payment.

Medicare or Other Insurance

It is important to tell us if you have other insurance or Medicare. It does not change any of the services or benefits you get from UnitedHealthcare Community Plan. Try to choose a PCP who works with both UnitedHealthcare Community Plan and your other insurance. This will help us coordinate your benefits.

Members who have both ALTCS and Medicare are called “dual eligible.” UnitedHealthcare Community Plan may help pay your coinsurance and deductibles if you use Medicare providers that are also contracted with UnitedHealthcare Community Plan or who follow all of UnitedHealthcare Community Plan’s cost-sharing rules.

Always tell your doctor if you have other insurance. Your other insurance or Medicare is considered your primary insurance. They may pay for your medical services. You must use your primary insurance plan first. UnitedHealthcare Community Plan is your secondary insurance. UnitedHealthcare Community Plan may help you pay copays, coinsurance or deductibles that other insurance may charge you. Make sure to show the doctor your UnitedHealthcare Community Plan ID card and your other insurance ID cards. This will help them to know where to send the bill. If you do not tell your doctor that you have other insurance, this may delay payment from UnitedHealthcare Community Plan.

Your Case manager will help you manage benefits. Make sure your Case Manager has all of your insurance information.

ALTCS benefits will not change your Medicare benefits. If you are dually eligible, you need to know that:

- If you have Traditional Medicare, your doctor may be registered with AHCCCS.
- If you see a doctor who is not with AHCCCS, you must pay your copay and deductible.
- If you are in a Medicare HMO/Advantage plan, your PCP will be the one from your Medicare HMO. You do not have to get another PCP for ALTCS.

Coordination of benefits/third party liability.
Your Medicaid benefits under AHCCCS are the payer of last resort. That means they will pay only after all other sources/insurance have been used.

Medicare Prescription Drug Benefit and AHCCCS Members

- Medicare, instead of AHCCCS, offers drug coverage. AHCCCS will still pay for your other covered health care costs.
- Medicare drug coverage is available to all qualifying people with Medicare.
- You must join and stay in a drug plan for Medicare to pay for your drugs.
- You are eligible for extra help with Medicare costs under Social Security's Extra Help.
- Medicare drug coverage is set up to pay for brand name and generic drugs.
- You can switch to another drug plan at any time.
- UnitedHealthcare Community Plan pays for some drugs not covered by Medicare. Drugs covered by UnitedHealthcare Community Plan do not have a copay.
- UnitedHealthcare Community Plan works with many pharmacies. Some are open 24 hours a day. If the pharmacy tells you a drug is not covered, ask them to contact the Pharmacy Benefits Manager.

More information is at **UHCCommunityPlan.com**.

Changes to drugs covered for members with Medicare effective January 1, 2013.
AHCCCS covers drugs which are medically necessary, cost-effective, and allowed by federal and state law.

For AHCCCS recipients with Medicare, AHCCCS does NOT pay for any drugs paid by Medicare, or for the cost-sharing (coinsurance, deductibles, and copayments) for these drugs. AHCCCS and its Contractors are prohibited from paying for these medications or the cost-sharing (coinsurance, deductibles, and copayments) for drugs available through Medicare Part D even if the member chooses not to enroll in the Part D plan.

Beginning January 1, 2013, AHCCCS will no longer pay for barbiturates to treat epilepsy, cancer, or mental health problems or any benzodiazepines for members with Medicare.

This is because federal law requires Medicare to begin paying for these drugs starting January 1, 2013. Some of the common names for benzodiazepines and barbiturates are:

Generic Name	Brand Name
Alprazolam	Xanax
Diazepam	Valium
Lorazepam	Ativan
Clorazepate Dipotassium	Tranxene
Chlordiazepoxide Hydrochloride	Librium
Clonazepam	Klonopin
Oxazepam	Serax
Temazepam	Restoril
Flurazepam	Dalmane
Phenobarbital	Phenobarbital
Mebaral	Mephobarbital

AHCCCS will still pay for barbiturates for Medicare members that are NOT used to treat epilepsy, cancer, or mental health problems even if it is after January 1, 2013.

Filing a Complaint or Grievance

If you have a problem or complaint about UnitedHealthcare Community Plan, ask your Case Manager or Member Services for help. If your Case Manager or Member Services is able to help you, your complaint will be considered resolved. In that case, you will not get any other notice.

If you are not happy with the response from your Case Manager or Member Services, you may file a grievance. Please see the "Member Grievance Process" below.

You may file a complaint or grievance against us (the managed care organization) or a provider with us.

If you do not feel the Notice of Adverse Benefit Determination letter is adequate or addresses your concerns, you can contact AHCCCS Medical Management at 602-417-4000 or 1-800-654-8713 outside of Maricopa County.

Member Grievance Process

Grievances Not Related to a Serious Mental Illness (SMI) Reason

Members can file a grievance orally with their Case Manager or call Member Services from 8:00 a.m. to 5:00 p.m. Monday through Friday at **1-800-293-3740**, **TTY 711**. All members can file a grievance through this process. Members designated with a Serious Mental Illness have a different grievance process in the next section if their grievance is related to rights, abuse, or mistreatment for behavioral health services. Please follow that process.

Members may also file a written grievance by sending it to:

UnitedHealthcare Community Plan
Attn: Grievance and Appeals
1 East Washington, Suite 900
Phoenix, AZ 85004

Once the Grievance Manager gets your complaint, it will be reviewed. Most grievances are resolved within 10 days but not more than 90 days.

If you need help in filing a grievance because you do not speak English and need an interpreter, or have a hearing or vision impairment, contact your Case Manager or call Member Services at **1-800-293-3740**, **TTY 711**. Grievance information is available in alternative formats.

If you are a person determined to have a serious mental illness (SMI), you can file a grievance/request for investigation if you feel that your rights have been violated. See "Grievance/Request for Investigation for Members Determined to Have a Serious Mental Illness" for more information.

Grievances/Requests for Investigation for a Serious Mental Illness (SMI) Reason

The SMI Grievance/Request for Investigation process applies only to adult persons who have been determined to have a serious mental illness and to any behavioral health services received by the member.

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

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

You have 12 months from the time that the rights violation happened to file an SMI Grievance/Request for Investigation having to do with any behavioral services that you received. You may file a Grievance/Request for Investigation orally or in writing. Grievance/Request for Investigation forms are available at UnitedHealthcare Community Plan and providers of behavioral health services. You may ask staff for help in filing your grievance.

Contact Member Services at **1-800-293-3740**, **TTY 711** or your Case Manager to make your oral or written Grievance/Request for Investigation.

To file a written Grievance/Request for Investigation directly, mail to:

UnitedHealthcare Community Plan
Attn: Grievance and Appeals
1 East Washington, Suite 900
Phoenix, AZ 85004

Grievances concerning physical abuse, sexual abuse or a person's death are investigated by AHCCCS. To file an oral or written grievance concerning physical abuse, sexual abuse or a person's death, contact AHCCCS Office of Grievance and Appeals, 701 E. Jefferson St., MD6200, Phoenix, AZ 85034, or call 602-364-4575, or fax 602-364-4591. Deaf or hard-of-hearing individuals may call the Arizona Relay Service at 711 or 1-800-367-8939 for help contacting AHCCCS.

AHCCCS will send you a letter within 5 days of getting your Grievance/Request for Investigation. This letter will tell you how your Grievance/Request for Investigation will be handled.

If there will be an investigation, the letter will tell you the name of the investigator. The investigator will contact you to hear more about your Grievance/Request for Investigation. The investigator will then contact the person that you feel was responsible for violating your rights. The investigator will also gather any other information they need to determine if your rights were violated.

Within 35 days of an investigator being assigned, unless an extension has been asked for, you will get a written decision of the findings, conclusions and recommendations of the investigation. You will also be told if you have the right to appeal the decision if you do not agree with the conclusions of the investigation.

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

Notice of Adverse Benefit Determination

If UnitedHealthcare Community Plan decides to reduce, suspend, or stop a service, you will get a **"Notice of Adverse Benefit Determination"**:

1. At least ten (10) days before the action.
2. At least five days before the date of action in the case of suspected fraud.

If UnitedHealthcare Community Plan **denies a service**, you will get a **"Notice of Adverse Benefit Determination."** It must say:

1. The action we have taken or intend to take.
2. The reasons for the action.
3. The member's right to file an appeal.
4. How to do this.
5. When an expedited appeal is available. How to request it.
6. The right to get ongoing benefits pending resolution. How to request ongoing benefits. When the member may need to pay for these services.

If you do not agree with this action, you may file an appeal. You may file an appeal of:

- The denial or limiting of a service.
- The reduction, suspension or stopping of an authorized service.
- The denial in whole or in part of payment for service.
- The failure to provide services in a timely manner.
- The failure to meet the time limits for appeals.
- The denial of a rural enrollee's request for services outside the network when the plan is the only one in the area.

Member Appeals

Appeals Not Related to a Serious Mental Illness (SMI)

All members can file an appeal through this process. Members designated with a Serious Mental Illness have a different appeal process in the next section if their appeal is related to SMI reasons. Please follow that process.

Standard Appeal.
A Standard Appeal is a request to UnitedHealthcare Community Plan to review a decision or action with which you do not agree.

- UnitedHealthcare Community Plan must get an appeal from you, or your agent, no later than 60 days from the date of the Notice of Adverse Benefit Information letter you received.
- UnitedHealthcare Community Plan will acknowledge receipt of standard appeals in writing within five business days.
- Within one business day for expedited appeals.
- You may request your appeal verbally or in writing. Oral inquiries appealing an action are treated as appeals.
- We will review all the facts we have on your appeal.
- You have the right to give us information in person or in writing before a decision is made.
- You may review your case file before and during the process.
- People who make decisions on appeals were not involved in the original authorization.
- If the appeal is for a clinical service, decisions are made by professionals with appropriate clinical expertise.
- Once all the information about your appeal is reviewed, we will send you a decision. You will get this within 30 days after we get your appeal.
- Your provider or authorized representative may file an appeal on your behalf, as long as you have given them written consent.

Notice of extension letters.

- It may be in your best interest to ask for an extension.
- UnitedHealthcare Community Plan may also request an extension in your best interest to avoid denying the request because we do not have all the information needed to approve the request. You can also provide additional information to support your request.
- An extension may be granted for up to 14 calendar days. If we ask for an extension, we will tell you in writing.

Expedited appeal.
If you think you cannot wait for a standard appeal, you may request an "expedited appeal." You must:

- Believe the standard appeal process would risk your life, health or ability to regain maximum function. For more on an expedited appeal, call Member Services at **1-800-293-3740**, **TTY 711**.

You may file your expedited appeal verbally or in writing. If we decide that your request does not meet the criteria above, it will be changed to a standard appeal. This decision is made by a UnitedHealthcare Community Plan Medical Director, Utilization Manager or other medical professional. We will tell you this in writing. Your request for an expedited appeal will then be handled like a standard appeal.

- You have the right to give information to us before the decision.
- You may review your case file before and during the process. To do so, call us at **1-800-293-3740**, **TTY 711**.
- If your request for an expedited appeal is approved, you will get a decision within three (3) business days.
- If a decision is not made by the end of that time, the request will be denied.
- After UnitedHealthcare Community Plan has reviewed your appeal, you will get a written decision. This notice will tell how we made our decision. It will also include the references such as laws, rules and policies, and the date of the decision.

Appeals process.

- You may have someone help you in the appeals process or file the appeal for you. This may be a provider. You must give written consent for this.
- UnitedHealthcare Community Plan will not retaliate against the member or provider for filing an appeal.
- During the appeals process, you may be able to keep getting benefits. The requirements are:
  - You request an extension of your benefits.
  - Your appeal involves stopping or reducing an authorized treatment.
  - The services were ordered by an authorized provider.
  - You file the appeal before the action or within ten (10) days of the Notice of Adverse Benefit Information, whichever is later.
- A provider may represent you in the appeal hearing if you give written permission.

If you want to continue your benefits, you will have to pay for any benefits you get during the appeal and State Fair Hearing if the decision is not in your favor.

Notice of appeal resolution.
The member will get a resolution letter that will contain:

1. The results of the resolution.
2. For appeals not wholly in your favor:
   a. The right to request a State Fair Hearing and how to do so.
   b. The right to continue benefits pending the hearing.
   c. How to request continued benefits.
   d. Notice that you may be liable for the cost of benefits if the State Fair Hearing upholds UnitedHealthcare Community Plan's position.

State Fair Hearing.

- If you are not satisfied with an appeal, you may request a State Fair Hearing.
- A provider may represent you if you give permission.
- You must notify UnitedHealthcare Community Plan in writing no later than 30 days from the date you receive the appeal decision if you want a hearing.
- We will contact ALTCS, who will arrange your State Fair Hearing. A judge conducts the hearing.
- You may represent yourself or use a lawyer, a relative, a friend, or other representative if you give written consent.
- Before and during the hearing, you have the right to review your case file. You may review the documents that may be considered. You may bring your own witnesses. You may present any information on your case.
- After the proceeding, the judge will issue a Recommended Decision to ALTCS.
- ALTCS will review the decision and mail the Director's Decision to the member.

The process for a hearing will be stated on the letter. Or you may contact Member Services or your Case Manager.

Appeals for SMI Determination and for Other SMI Reasons

A serious mental illness (SMI) is a mental disorder in persons 18 years of age or older that's severe and persistent. Crisis Response Network (CRN), a provider that has a contract with UnitedHealthcare Community Plan, will make a determination of serious mental illness upon referral or request.

Members asking for a determination of serious mental illness and members who have been determined to have a serious mental illness can appeal the result of a serious mental illness determination.

CRN will send you a letter by mail to let you know the final decision on your SMI determination. This letter is called a Notice of Decision. The letter will include information about your rights and how to appeal the decision. To file an appeal, you can call CRN at 1-855-832-2866.

Persons who have been determined to have a serious mental illness can also appeal certain aspects of their treatment plan.

Persons determined to have a serious mental illness may also appeal the following adverse decisions:

- A decision regarding fees or waivers.
- The assessment report and recommended services in the service plan or individual treatment or discharge plan.
- The denial, reduction, suspension or termination of any service that is a covered service funded through Non-Title 19/21 funds.*
- Capacity to make decisions, need for guardianship or other protective services or need for special assistance.

**Persons determined to have a serious mental illness cannot appeal a decision to deny, suspend or terminate services that are no longer available due to a reduction in State funding.*

What happens after I file an SMI appeal?

If you file an appeal, you will get written notice that your appeal was received within 5 working days of UnitedHealthcare Community Plan's receipt. You will have an informal conference with UnitedHealthcare Community Plan within 7 working days of filing the appeal. The informal conference must happen at a time and place that is convenient for you. You have the right to have a designated representative of your choice assist you at the conference. You and any other participants will be informed of the time and location of the conference in writing at least 2 working days before the conference. You can participate in the conference over the telephone.

For an appeal that needs to be expedited, you will get written notice that your appeal was received within 1 working day of UnitedHealthcare Community Plan's receipt, and the informal conference must occur within 2 working days of filing the appeal.

If the appeal is resolved to your satisfaction at the informal conference, you will get a written notice that describes the reason for the appeal, the issues involved, the resolution achieved and the date that the resolution will be implemented. If there is no resolution of the appeal during this informal conference, the next step is a second informal conference with AHCCCS. You may waive the second level informal conference and proceed to a State Fair Hearing, however. If you waive the second level informal conference with AHCCCS, UnitedHealthcare Community Plan will assist you in filing a request for State Fair Hearing at the conclusion of the UnitedHealthcare Community Plan informal conference.

If there is no resolution of the appeal during the second informal conference with AHCCCS, you will be given information that will tell you how to get a State Fair Hearing. The Office of Grievance and Appeals at AHCCCS handles requests for State Fair Hearings upon the conclusion of second level informal conferences.

Will my services continue during the appeal process?
If you file an appeal, you will continue to get any services you were already getting unless a qualified clinician decides that reducing or terminating services is best for you, or you agree in writing to reducing or terminating services. If the appeal is not decided in your favor, UnitedHealthcare Community Plan may require you to pay for the services you received during the appeal process.

Questions and Answers on Appeals

Q: What if I need help in filing an appeal or need an interpreter?

A: If you need help in filing a grievance because you do not speak English and need an interpreter, or have a hearing or vision impairment, contact your Case Manager or call Member Services at **1-800-293-3740**, **TTY 711**.

Q: How do I file an appeal?

A: You may file an appeal over the phone or in writing. All letters of appeal must be sent to:

UnitedHealthcare Community Plan Appeal Manager
1 East Washington, Suite 900
Phoenix, AZ 85004

Or call Member Services at **1-800-293-3740**, **TTY 711**.

You may file a complaint or grievance against us (the managed care organization) or a provider with us. Refer to the Member Grievance Process for details on filing.

Member Rights

You have the right to:

- You have a right to file a complaint or grievance about the health plan.
- The right to request information on the structure and operation of the health plan or its subcontractors.
- Ask UnitedHealthcare Community Plan about any Physician Incentive Plans that affect the use of referral services.
- The right to know the types of compensation arrangements the health plan uses.
- Know whether stop loss insurance is needed.
- Get member survey summaries.
- The right to be treated fairly regardless of your race, color, national origin, sex, age, disability, politics, religion, ability to pay, or past health.
- Be examined with privacy.
- Talk about your medical care in private.
- Have your medical records read only by people involved in your care or if you give specific permission.
- Have records about your care, including your being in ALTCS, kept private.
- Coordination of care with schools and state agencies may occur, within the limits of applicable regulations [42 CFR 438.10(e)(2)(i)(c)].
- Request a second opinion from a qualified health care professional within UnitedHealthcare Community Plan's network at no cost to you. A second opinion may be received from an out-of-network provider, at no cost to you, if there is no in-network coverage.
- Get information from your doctor on your diagnosis, care and possible outcome(s).
- Get information on treatment options in a format you can understand or that your Case Manager will explain.
- Get a replacement caregiver for critical services within 2 hours.
- Provided with information on how to set up Advance Directives.
- **You have the right to request a copy of your medical record annually at no cost to you upon your written request.**
- That UnitedHealthcare Community Plan must reply within 30 days to a member's request for a copy of his or her records. The response may be the copy of the record. Or it may be a written denial with the basis for the denial and information about how to seek review of the denial per 45 CFR Part 164 (AMPM 930.1.iv).
- To request your medical record be amended or corrected per 42 CFR part 164.
- To be free from restraint or seclusion as coercion, discipline, convenience, or retaliation, per federal law.

- Receive information on beneficiary or plan information.
- You will be treated with respect and due consideration for your dignity and privacy.
- Participate in decisions regarding your health care, including the right to refuse treatment.
- Get a list of our providers at no charge that shows what languages the doctors speak. Call Member Services at **1-800-293-3740**, **TTY 711** or your Case Manager for a listing.
- Go to any hospital or other setting for emergency care.

Your Right for an Advance Directive

All patients in hospitals, nursing centers, and other health care settings have rights. You have the right to have your personal and medical records kept private. You have the right to know what treatment you will get.

Per federal law, you have the right to make an **"Advance Directive."** This is a document that says in advance what treatment you want or do not want. This is useful when you can't tell medical staff your wishes. This section will help explain this law. It requires hospitals, nursing centers, and other providers to tell you about Advance Directives. It outlines your choices in making decisions about medical care. The law increases your control over treatment decisions.

Some helpful websites are:
Arizona Attorney General's Life Care Planning site at: **http://www.azag.gov/life_care**
Arizona Advance Directive Registry at: **http://www.azsos.gov/adv_dir/**

Q: What is an Advance Directive?

A: It is a written statement about how you want your health decisions made. Under Arizona law, there are three common types. These are:

1. A Health Care Power of Attorney
2. A Living Will
3. Pre-Hospital Medical Care Directive

1. **A Health Care Power of Attorney** — is a legal document where you name an adult to make health care decisions for you when you cannot make or let others know of such decisions.

   The Health Care Power of Attorney must:

   - State the name of the person you want to make health care decisions for you.
   - State that this person may only make health care decisions for you when you cannot, if that is what you want.
   - Be dated and signed by you.

Your Health Care Power of Attorney may also:

- Include details about health care you want or do not want. This could include withholding procedures if you are in a "terminal condition." A "terminal condition" is when a patient cannot be cured and will die without life-sustaining procedures. (This must be stated in writing by two doctors.) A "terminal condition" is also if a patient is in a permanent vegetative state or an irreversible coma.
- Name a second person to make these decisions if the first person is not able to do so.
- Include signatures of witnesses who are not related to you.

2. **A Living Will** — is a written statement (legal document) about health care you want or do not want if you cannot make these decisions. A Living Will can say if you want to be fed with a tube if you are not conscious and unlikely to recover or if you cannot eat or drink. A Living Will may direct doctors to withhold or continue procedures if you are in a "terminal condition." You can tell doctors whether to use other life-sustaining procedures. Your doctors will use your Living Will only if you are not able to state your health care decisions.

   General advice on making a valid Living Will:

   - Obtain a Living Will from your attorney or from dependable professional sources, such as stationery stores or trustworthy online sites.
   - Sign and date your Living Will in front of two witnesses who must also sign it.
   - Neither witness may be directly involved in your care.

   In addition, one of the witnesses must not:

   - Be related to you by blood or marriage.
   - Have a right to any of your estate.
   - Have a claim against the estate.
   - Directly pay for your medical care.

3. **A Pre-Hospital Medical Care Directive** — is a written directive (legal document) refusing certain lifesaving care given outside a hospital or in an emergency room. This must be completed as required by law. This form will list these types of treatments you may refuse:

   - Chest compression (to restart your heart).
   - Defibrillation (electronically correcting the heart beat).
   - Assisted ventilation (breathing by machine).
   - Intubation (supplying air through a tube).
   - Advanced life support drugs.

   If you want a Pre-Hospital Directive, talk to your PCP.

   Also, a Pre-Hospital Directive must:

   - Be signed or marked by you and dated.
   - Be signed by a licensed health care provider and a witness.

Q: Who has the right to make health care decisions?

A: You do, if you are able to make and let providers know of your decisions. You decide what health care, if any, you will not accept.

Q: What if I become unable to make or let providers know of my health care decisions?

A: You can still have some control if you have an Advance Directive. Your provider must put in your record if you have an Advance Directive. If you have not named someone in your Advance Directive, your PCP must seek a person authorized by law to make such decisions.

Q: Must my Advance Directive be followed?

A: Yes. Health care providers and the person you name in your directive must follow a valid Advance Directive.

Q: Must a lawyer write my Advance Directive?

A: Not necessarily; however, it is good practice and advisable to have a lawyer or legal advisor review any legal document. Local and national groups can give you facts and forms. Be sure any Advance Directive you use is valid under Arizona law.

Q: Who should have a copy of my Advance Directive?

A: Give a copy to your PCP. Give it to any health care center on admission. If you have a Health Care Power of Attorney, give a copy to the person you have named on it. Keep extra copies for yourself and your Case Manager. Also, keep your copy in a place that is safe and easy to get to.

Q: Can I be required to make an Advance Directive?

A: No. Whether you make one is up to you. A provider cannot refuse care based on whether you have one.

Q: Can I change or cancel my Advance Directive?

A: Yes, but it is important you follow the same steps as outlined above. If you change or cancel it, let your Case Manager and PCP know.

Q: What if I already have an Advance Directive?

A: You may want to review it or have it reviewed by an attorney or legal advisor. If it was done in another state, make sure it is valid in Arizona. If you did it before September 1992, the law has changed. New choices are available so you may consider making a new one.

Q: Does Arizona law limit what can be done under an Advance Directive?

A: The Arizona law does not allow acts or omission (not acting) leading to the injury or death of physically or mentally impaired adults. It is important to have a proper Advance Directive that states your wishes on the treatment(s) you do/do not want.

Q: Who can legally make health care decisions for me if I cannot make them and I have no Advance Directive?

A: A court may appoint a guardian to make health care decisions for you. Otherwise, your health care provider must go down this list to find someone:

- Your husband or wife, unless you are legally separated.
- Your adult child. If you have more than one adult child, a majority of them.
- Your mother or father.
- Your domestic partner, unless someone else has financial responsibility for you.
- Your brother or sister.
- A close friend of yours. (Someone who shows special concern for you and knows your health care views.)

If your provider cannot find a person to make health care decisions for you, your PCP can decide. Your PCP can do this with an ethics committee or the approval of another physician.

You can keep anyone from making decisions for you by saying so in writing. For example, the person you name in your Advance Directive will not have the right to refuse the use of tubes to give you food or fluids — if this is what you want — unless:

- You have appointed that person to make decisions for you in a Health Care Power of Attorney.
- A court has appointed that person as your guardian to make health care decisions for you.
- You have stated in an Advance Directive that you do not want this treatment.

If you have questions about Advance Directives, ask your Case Manager.

** UnitedHealthcare Community Plan is providing general Advance Directive information; ALWAYS CONSULT YOUR LAWYER OR LEGAL ADVISOR BEFORE SIGNING ANY LEGAL DOCUMENT.*

Fraud and Abuse

Fraud and abuse are generally wrongs done to others. Fraud and abuse is ilegal. Committing acts that are fraudulent or abusive may cause you to lose your ALTCS eligibility. Penalties include fines or jail.

Definitions:

Fraud.
Fraud is defined by federal law (42 CFR 455.2). It is an intentional deception or misrepresentation made with the knowledge that the deception could result in an unauthorized benefit. It includes any act that constitutes fraud under federal or state law.

Abuse.
Abuse is defined by federal law (42 CFR 455.2). It includes provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to Medicaid. Or it can be reimbursement for services that are not medically necessary or fail to meet professional standards. It also includes recipient practices that result in unnecessary cost to Medicaid.

Abuse of member.
Abuse of a member is defined by Arizona law (A.R.S. 46-451 and 13-3623). It means any intentional, knowing or reckless infliction of physical harm, injury caused by negligent acts or omissions, unreasonable confinement, emotional or sexual abuse, or sexual assault.

Examples of fraud and abuse.

- If you do not tell your AHCCCS eligibility worker or Case Manager that you got a large sum of money or sold your house (Transfer/Hiding).
- If you make up an address of where you are living.
- Pretending to have more or fewer people living in your house.
- If you are not honest about being a United States citizen.
- Unreported income — If you do not tell AHCCCS or your Case Manager that you are getting money.
- Misrepresenting medical condition — If you are not truthful about your health.
- Failure to report Third Party Liability (TPL) — If you do not tell AHCCCS or your Case Manager about other insurance you have.
- Failure to notify your Case Manager and AHCCCS when there is a change in family size or other demographic changes.

A provider may commit fraud or abuse. Examples are:

- Giving you care you do not need.
- Billing for services you did not get.
- Keeping you in a hospital longer than you need.
- Inflicting mental or physical harm.
- Misuse of your trust fund.
- Failure to carry out your plan of care.

If you think fraud or abuse is going on with providers, staff, or other members, call Member Services at **1-800-293-3740**, **TTY 711**. We will not use your name in your report. You will not get in trouble for reporting this. We will look into the matter for you. You can also call AHCCCS at **1-888-487-6686** or **602-417-4193** or go to their website at **www.azahcccs.gov**. You do not have to give your name.

Community Resources

Help to Stop Smoking

Would you like to make a plan to quit smoking?

There are community support groups, cessation treatment, care and services available to members available at **www.azdhs.gov/tobaccofreeaz/**. Or contact ASHLine Quit NOW.

1-800-556-6222

For Prescription to Quit, ASHLine will call you back within three days. If you're ready to QUIT NOW do not wait, call now **1-800-556-6222**.

www.ashline.org

Diabetes Care

American Diabetes Association:
http://www.diabetes.org

You can also call the American Diabetes Association at **1-800-DIABETES** (1-800-342-2383).
Hours are Monday – Friday, 8:30 a.m. to 8:00 p.m., Eastern Standard Time.

Or write:

American Diabetes Association
ATTN: Center for Information
2451 Crystal Drive, Suite 900
Arlington, VA 22202

Arizona Alzheimer's Association

http://www.alz.org/dsw/ or by phone:
1-800-272-3900 for the Alzheimer's Association 24-hour helpline.

Arizona Governor's Council on Spinal and Head Injuries

http://www.azheadspine.org
or by phone: **1-602-774-9147**.

Community Information and Referral

The website and contacts below have information on Housing and Shelter, Help Paying Bills, Mental Health and Support Groups and much more.

https://211arizona.org/
2-1-1 within Arizona.
1-877-211-8661 from anywhere.
1-602-263-8845 Administration.
1-602-263-0979 fax.
1-800-367-8939 TDD (Arizona Relay).

National Alliance on Mental Illness (NAMI)

NAMI is the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness.

http://www.namiaz.com
602-244-8166

Arizona Coalition Against Sexual and Domestic Violence

Their mission is to lead, to advocate, to educate, to collaborate, to prevent and end sexual and domestic violence in Arizona.

http://www.acesdv.org/

Locally: 602-279-2900
Toll-Free: 1-800-782-6400
TTD/TTY: 602-279-7270

Health-e-Arizona Plus

www.healthearizonaplus.gov
Allows AHCCCS members to view information about their health care and plan enrollment for:

- AHCCCS.
- Part D, which is the Medicare prescription drug benefit.
- KidsCare.
- Behavioral Health.
- Medicare.
- Other Medical Insurance.

AHCCCS members may also view two years of enrollment information. Members can link to their health plan websites. Members can view their health plan enrollment date. They can link to the annual enrollment change website. Members can verify if AHCCCS has their correct address.

AZ Links

AZ Links is Arizona's Aging and Disability Resource Center (ADRC), created to help Arizona Seniors, People with Disabilities, Caregivers and their Family Members locate resources and services that meet their needs.

Visit **www.azlinks.gov**.

Arizona 211

This website helps you find resources from child care, jobs, health care, and insurance. It shows bulletins and alerts for disaster or emergency. It partners with government, tribal, non-profit and community groups to help you find resources.

Visit **https://211arizona.org/**.

WIC

The Arizona Women, Infants, and Children Program (WIC) provides Arizona residents with nourishing supplemental foods, nutrition education, and referrals. People who use WIC are women who either are pregnant, breastfeeding, or have just had a baby; and infants and children who have nutritional needs and meet income guidelines. Call the WIC hotline at 1-800-252-5942 or visit **www.azwic.gov** for more information.

Area Agency on Aging

The Area Agencies on Aging (AAA) were established through the Older Americans Act amendments of 1972 in order to provide a local structure for addressing the needs and concerns of older persons. The goal of an Area Agency on Aging is to enable older people to maintain maximum independence and dignity within their own homes and communities as long as possible by developing a system of coordinated, comprehensive services to meet their needs. The AAA also provides State Health Insurance Assistance Programs (SHIP). They can educate about Medicare and the different Medicare Plan options. The AAAs are listed below by county.

MARICOPA COUNTY
http://www.aaaphx.org/

Area Agency on Aging, Region One
1366 East Thomas Road, Suite 108
Phoenix, AZ 85014
Phone: **602-264-2255** Fax: **602-230-9132**
Toll-Free: **1-888-783-7500**

COCONINO, YAVAPAI, APACHE, AND NAVAJO COUNTIES
http://nacog.org/

Northern Arizona Council of Governments (NACOG)
43 South San Francisco Street
Flagstaff, AZ 86001
Phone: **928-213-5226** Fax: **928-214-7235**
Toll-Free: **1-877-521-3500**

LAPAZ, MOHAVE, AND YUMA COUNTIES
http://www.wacog.com/

Western Arizona Council of Governments (WACOG)
Central Intake Phone: **1-800-782-1886**

MOHAVE COUNTY

208 North Fourth Street
Kingman, AZ 86401
Phone: **928-753-6247**

GILA AND PINAL COUNTIES

Area Agency on Aging, Region Five
Pinal-Gila Council For Senior Citizens
8969 W. McCartney Road
Casa Grande, AZ 85294-7432
Phone: **520-836-2758**
Toll-Free: **1-800-293-9393**

PIMA COUNTY
http://www.pcoa.org/

Pima Council on Aging
8467 East Broadway Blvd.
Tucson, AZ 85710
Phone: **520-790-7262**
Fax: **520-790-7577**

Support and Advocacy

Contact your Case Manager if you need assistance getting services.

Centers for independent living.

Maricopa County:
Ability 360
ABIL-5025 East Washington Street
Phoenix, AZ 85034
602-667-0277
Toll-Free: **1-800 280-2245**
TTY: **602-296-0591**

Northern Arizona: all counties
New Horizons Independent Living
8085 East Manley Drive
Prescott Valley, AZ 86314
Voice/TTY: **928-772-1266**
All counties: Toll-Free: **1-800-406-2377**

Coconino, Navajo, and Apache Counties:
ASSIST! to Independence
P.O. Box 4133
Tuba City, AZ 86045
1-928-283-6261

Arizona Center for Disability Law
5025 East Washington Street, Suite 202
Phoenix, AZ 85034
Phone: **602-274-6287** (voice or TTY)
1-800-927-2260 (toll-free)
Fax: **602-274-6779**
Website: **http://www.acdl.com/**

Behavioral Health Advocacy

Mental Health America of Arizona (MHAAZ)

http://www.mhaarizona.org/
Contact Mental Health America of Arizona weekdays by calling **1-480-994-4407**, outside Maricopa County, **1-800-MHA-9277** (or fax: **1-480-994-4744)**.

MHAAZ's Mailing Address is:

Mental Health America of Arizona
5110 N 40th Street, Suite 201
Phoenix, AZ 85018

National Alliance on Mental Illness (NAMI)

NAMI is the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness.

http://www.namiaz.com
602-244-8166

Arizona Center for Disability Law (ACDL)

ACDL is a not-for-profit which is dedicated to protecting the rights of individuals with physical, mental, psychiatric, sensory and cognitive disabilities.

https://www.azdisabilitylaw.org/

ALTCS Advocates and Advocacy Systems

Long Term Care Ombudsman

The program grew out of efforts by both federal and state governments to respond to widely reported concerns that our most frail and vulnerable citizens (those living in long term care facilities) were subject to abuse, neglect and substandard care. These residents also lacked the ability to exercise their rights or voice complaints about their circumstances. The primary purpose of the Long Term Care Ombudsman Program is to identify, investigate and resolve complaints made by or on behalf of residents of long term care facilities.

- Educating residents, families, facility staff and the community about long term care issues and services.
- Promoting and advocating for residents' rights.
- Assisting residents in obtaining needed services.
- Working with and supporting family and resident councils.
- Empowering residents and families to advocate for themselves.

The Ombudsman Program will make every reasonable effort to assist, advocate and intervene on behalf of the resident. When investigating complaints, the program will respect the resident and the complainant's confidentiality and will focus complaint resolution on the resident's wishes.

The Ombudsman Program accepts complaints from any source. If you have a complaint, concern or would like more information, the Ombudsman Program is available to assist you. To contact your local Long Term Care Ombudsman, contact your local Area Agency on Aging.

Centers for Independent Living

Maricopa County:
Ability 360
ABIL-5025 East Washington Street
Phoenix, AZ 85034
602-667-0277
Toll-Free: **1-800 280-2245**
TTY: **602-296-0591**

Northern Arizona: all counties
New Horizons Independent Living
8085 East Manley Drive
Prescott Valley, AZ 86314
Voice/TTY: **928-772-1266**
All counties: Toll-Free: **1-800-406-2377**

Coconino, Navajo, and Apache Counties:
ASSIST! to Independence
P.O. Box 4133
Tuba City, AZ 86045
1-928-283-6261

Arizona Center for Disability Law
5025 East Washington Street, Suite 202
Phoenix, AZ 85034
Phone: **602-274-6287** (voice or TTY)
1-800-927-2260 (toll-free)
Fax: **602-274-6779**
Website: **http://www.acdl.com/**

Legal Aid

APACHE COUNTY
White Mountain Legal Aid
a division of Southern Arizona Legal Aid
5658 Highway 260, Suite 15
Lakeside, AZ 85929
Phone: **928-537-8383 / 1-800-658-7958**

COCHISE COUNTY
Southern Arizona Legal Aid
2 Copper Queen Plaza, Upstairs
P.O. Box AL, Bisbee, AZ 85603
Phone: **520-432-1639 / 1-800-231-7106**

COCONINO COUNTY
DNA People's Legal Services
2323 East Greenlaw Lane
Flagstaff, AZ 86004
Phone: **928-774-0653 / 1-800-789-5781**

GILA COUNTY
White Mountain Legal Aid
a division of Southern Arizona Legal Aid
5658 Highway 260, Suite 15
Lakeside, AZ 85929
Phone: **928-537-8383 / 1-800-658-7958**

MARICOPA COUNTY
Community Legal Services
P.O. Box 21538
Phoenix, AZ 85036-1538
Phone: **602-258-3434 / 1-800-852-9075**

Community Legal Services
East Side Office
1220 South Alma School Road, #206
Mesa, AZ 85210
Phone: **480-833-1442 / 1-800-896-3631**

MOHAVE COUNTY
Community Legal Services
1720 Beverly, Suite A
Kingman, AZ 86409
Phone: **928-681-1177 / 1-800-255-9031**

NAVAJO NATION
DNA – Chinle Agency Office
P.O. Box 767
Chinle, AZ 86503
Phone: **928-674-5242 / 1-800-789-7598**

DNA – Fort Defiance Agency Office
P.O. Box 306
Window Rock, AZ 86515
Phone: **928-871-4151 / 1-800-789-7287**

DNA – Hopi Legal Services
P.O. Box 558
Keams Canyon, AZ 86034
Phone: **928-738-2251 / 1-800-789-9586**

DNA – Tuba City Agency Office
P.O. Box 765
Tuba City, AZ 86045
Phone: **928-283-5265 / 1-800-789-8919**
Fax: **928-283-5460**

Native American Disability Law Center
Farmington Office
3535 East 30th Street, Suite 201
Farmington, NM 87410
Phone: **505-566-5880 / 1-800-862-7271**

Gallup Office
207 South Second Street
Gallup, NM 87301
Phone: **505-863-7455 / 1-877-283-3208**

PINAL COUNTY
Southern Arizona Legal Aid
766 North Park Avenue
Casa Grande, AZ 85222
Phone: **520-316-8076 / 1-877-718-8086**

NAVAJO COUNTY
White Mountain Legal Aid
a division of Southern Arizona Legal Aid
5658 Highway 260, Suite 15
Lakeside, AZ 85929
Phone: **928-537-8383 / 1-800-658-7958**

Native American Disability Law Center
Farmington Office
3535 East 30th St., Suite 201
Farmington, NM 87402
Phone: **505-566-5880 / 1-800-862-7271**

Gallup Office
207 South Second Street
Gallup, NM 87301
Phone: **505-863-7455 / 877-283-3208**

WHITE MOUNTAIN APACHE TRIBE
White Mountain Apache Legal Aid
a division of Southern Arizona Legal Aid
116 East Oak Street or P.O. Box 1030
Whiteriver, AZ 85941
Phone: **928-338-4845 / 1-866-312-2291**

YAVAPAI COUNTY
Community Legal Services
401 North Mt. Vernon
Prescott, AZ 86301
Phone: **928-445-9240 / 1-800-233-5114**

STATEWIDE
Arizona Center for Disability Law
5025 East Washington Street, Suite 202
Phoenix, AZ 85034
Phone: **602-274-6287 / 1-800-927-2260**

General legal information about your rights and website for each legal aid office:
www.azlawhelp.org

Disability Benefits 101

Visit **az.db101.org/uhc** to discover how work may impact your benefits. It can help you understand your work incentive options, take control of your benefits and plan for your future. There are online benefit and work calculators for youth and adults. Some of the topics covered at Disability Benefits 101 include:

Your Situation: Take a personal approach to benefits planning.

Going to Work: Find job support and learn how a job can affect your benefits.

Young People and Benefits: Learn how to manage school, work and benefits, including tips for parents.

Cash Benefits: Learn about benefits that can help you meet your basic needs.

Health Care Coverage: Explore many health coverage options, from public and private sources.

AHCCCS Freedom to Work Program: Learn how state and federal programs can support your career plans.

For additional information or assistance accessing AZDB101, please contact your Case Manager who has direct access to our Education and Employment Specialist.

Arizona Center for Disability Law (ACDL)

ACDL is a not-for-profit which is dedicated to protecting the rights of individuals with physical, mental, psychiatric, sensory and cognitive disabilities.

https://www.azdisabilitylaw.org/

Low-Income Housing

For information on low-income housing and shelter:

https://211arizona.org/

Community Dental Resources in Arizona

Clinic/ Organization	County	Phone Number	Address	Website
Adelante Healthcare	Maricopa	623-386-1630	306 E Monroe Buckeye, AZ 85326	http://www.adelantehealthcare.com
Adelante Healthcare	Maricopa	480-274-7303	1705 W Main St Mesa, AZ 85201	http://www.adelantehealthcare.com
Adelante Healthcare	Maricopa	623-544-5189	15351 W Bell Rd Surprise, AZ 85374	http://www.adelantehealthcare.com
Arizona School of Dentistry and Oral Health	Maricopa	480-248-8100	5855 E Still Circle Mesa, AZ 85206	http://www.atsudental.com/home
Canyonlands Community Healthcare	Coconino	928-643-6215	827 Vista Ave Page, AZ 86040	http://cchcaz.org
Canyonlands Community Healthcare	Navajo	928-697-8154	Chilchinbeto Clinic Kayenta, AZ 86033	http://cchcaz.org
Canyonlands Community Healthcare (Beaver Dam)	Mohave	928-347-5971	3272 East Rio Virgin Rd Beaver Dam, AZ 86432	http://cchcaz.org
CARE Partnership	Maricopa	480-833-8987	466 S. Bellview Mesa, AZ 85204 (call for appointment)	http://carepartnership.org
CASS Homeless Shelter	Maricopa	602-256-6945	230 S. 12th Ave Phoenix, AZ 85007	http://www.cassaz.org/programs/dental
Chandler Family Dental Clinic (MIHS) Chandler	Maricopa	480-344-6109	811 S Hamilton Chandler, AZ 85225	http://www.mihs.org/centers/facility-maps

Community Dental Resources in Arizona

Clinic/ Organization	County	Phone Number	Address	Website
Clinica Adelante/ Tidwell Care	Maricopa	623-386-1630	306 E Monroe Ave Buckeye, AZ 85326	http://www.adelantehealthcare.com
Coconino County Dept. of Health	Coconino	928-679-7825	304 S Humphreys Flagstaff, AZ 86001	http://www.coconino.az.gov/health
Dental Care West (ASDOH)	Maricopa	623-251-4700	20325 N 51st Ave Suite 156 Glendale, AZ 85308	http://www.atsudental.com
Donated Dental Services AZ Dental Foundation	480-850-1474 or 866-340-4337 to apply. Often a waiting list			http://www.azdentalfoundation.org
Fredonia Community Health Center	Coconino	928-643-6215	100 E Wood Hill Rd Fredonia, AZ 86022	http://cchcaz.org
Maricopa Integrated Health Systems (Avondale Family Health Center)	Maricopa	623-344-6800	950 E Van Buren St Avondale, AZ 85323	http://www.mihs.org/centers/facility-maps
Maricopa Integrated Health Systems (Comprehensive Healthcare Center)	Maricopa	602-344-1015	2525 E. Roosevelt St Phoenix, AZ 85008	http://www.mihs.org/centers/facility-maps

Community Dental Resources in Arizona

Clinic/ Organization	County	Phone Number	Address	Website
Maricopa Integrated Health Systems (Glendale Family Health Center)	Maricopa	623-344-6700	5141 W. Lamar St Glendale, AZ 85301	http://www.mihs.org/centers/facility-maps
Maricopa Integrated Health Systems (Mesa Family Health Center)	Maricopa	480-344-6209	59 S Hibbert Mesa, AZ 85210	http://www.mihs.org/centers/facility-maps
Maricopa Integrated Health Systems (South Central Family Health Center)	Maricopa	602-344-6400	33 W Tamarisk Phoenix, AZ 85041	http://www.mihs.org/centers/facility-maps
Mesa Comm Col Dent Hyg Clinic	Maricopa	480-248-8195	5855 E Still Circle Mesa, AZ 85206	http://www.mc.maricopa.edu/dept/d11/dental/hygiene/patient
Mohave Comm Col Dent Hyg Clinic	Mohave	928-704-7788	3400 Highway 95 Bullhead City, AZ 86442	http://www.mohave.edu
Mountain Park Health Center	Maricopa	602-243-7277	635 E Baseline Rd Phoenix, AZ 85042	http://www.mountainparkhealth.org/dental
Mountain Park Health Center	Maricopa	602-243-7277	6601 W. Thomas Rd Phoenix, AZ 85033	http://www.mountainparkhealth.org/dental

Community Dental Resources in Arizona

Clinic/ Organization	County	Phone Number	Address	Website
Native American Comm Health Center	Maricopa	602-279-5262	4520 N Central Ave Phoenix, AZ 85012	http://www.nativehealthphoenix.org/dental-services
Neighborhood Christian Clinic	Maricopa	602-258-6008	1929 W Fillmore St Bldg C Phoenix, AZ 85009	http://thechristianclinic.org
North Country Healthcare	Coconino	928-213-6151	2920 N 4th St Flagstaff, AZ 86004	http://www.northcountryhealthcare.org
North Country Healthcare	Coconino	928-637-2305	112 Park Ave Ash Fork, AZ 86320	http://www.northcountryhealthcare.org
North Country Healthcare	Navajo	928-289-2000	620 W. Lee St Winslow, AZ 86047	http://www.northcountryhealthcare.org
Northern AZ Univ Dent Hyg Clinic	Coconino	928-523-3500	NAU 208 Pine Knoll Dr Bldg. 66, Rm 216 Flagstaff, AZ 86011	http://nau.edu/CHHS/DDH/Clinic
Phoenix Col Dental Hyg Clinic	Maricopa	602-285-7323	1202 W Thomas Rd Bldg R Phoenix, AZ 85013	http://www.phoenixcollege.edu/student-resources/campus-resources/dental-clinic
Phoenix Indian Medical Center	Maricopa	602-263-1592	4212 N 16th St Phoenix, AZ 85016	http://www.ihs.gov/FacilitiesServices/areaOffices/Phoenix
Rio Salado Dent Hyg Clinic	Maricopa	480-377-4100	2250 W 14th St Tempe, AZ 85281	http://www.riosalado.edu/locations/dh/Pages/default.aspx

Community Dental Resources in Arizona

Clinic/ Organization	County	Phone Number	Address	Website
Salt River Health Center	Maricopa	480-946-9066	10005 E Osborn Rd Scottsdale, AZ 85256	http://www.ihs.gov/FacilitiesServices/areaOffices/Phoenix
Smiles for Success	1-800-920-2293 Nationwide AZ dentists working through Smiles for Success restore women's smiles, free. Must meet eligibility requirements ... call for details.			http://www.smilesforsuccess.org
St. Vincent de Paul Dental Clinic	Maricopa	602-261-6868	420 W Watkins Rd Phoenix, AZ 85002	http://www.stvincentdepaul.net/PS-VirginiaGPiper.htm
Sun Life Family Health Center	Pinal	520-836-3446	865 N. Arizola Rd Casa Grande, AZ	http://www.sunlifefamilyhealth.org
VA Medical Center Dental Clinic (100% disabled)	Maricopa	602-277-5551 ext: 1-6424	650 E. Indian School Rd. Phoenix, AZ 85012	http://www.phoenix.va.gov/services/Dental_Service.asp
VA Medical Center Dental Clinic (100% disabled)	Yavapai	928-445-4860 ext: 6582	500 N Hwy 89 Bldg 155, 1st Floor Prescott, AZ 86313	http://www.prescott.va.gov/services/Dental_Service.asp
Wesley Community Center	Maricopa	602-257-4323	1300 S 10th St Phoenix, AZ 85034	http://www.aachc.org/locations
Yavapai Community Health Center	Yavapai	928-639-8132	51 Brian Mickelsen Pkwy Cottonwood, AZ 86326	http://www.chcy.info

Arizona Long Term Care Offices

If you have questions about your share of cost or eligibility, call the ALTCS office in your area.

Casa Grande ALTCS Office
500 North Florence Street
Casa Grande, AZ 85222
Phone: **1-520-421-1500**
Toll-Free: **1-855-277-0260**
Fax: **1-877-666-0874**

Chinle ALTCS Office
Tseyi Shopping Center, Hwy. 191
P.O. Box 1942
Chinle, AZ 86503
Phone: **1-928-674-5439**
Fax: **1-877-660-1450**
Toll-Free: **1-888-800-3804**

Cottonwood ALTCS Office
Note: Cottonwood ALTCS staff are sharing space at the DES office.
1500 East Cherry Street, Suite I
Cottonwood, AZ 86326
Phone: **1-928-634-8101**
Toll-Free: **1-855-873-0393**
Fax: **1-877-666-5208**

Flagstaff ALTCS Office
2717 North Fourth Street, Suite 130
Flagstaff, AZ 86004
Phone: **1-928-527-4104**
Fax: **1-877-663-5213**
Toll-Free: **1-800-540-5042**

Globe/Miami ALTCS Office
Cobre Valle Plaza
2250 Highway 60, Suite H
Miami, AZ 85539-9700
Phone: **1-928-425-3165**
Fax: **1-877-666-5219**
Toll-Free: **1-888-425-3165**

Kingman ALTCS Office
519 East Beale Street, Suite 150
Kingman, AZ 86401
Phone: **1-928-753-2828**
Fax: **1-877-667-5239**
Toll-Free: **1-888-300-8348**

Lake Havasu ALTCS Office
2160 North McCulloch Boulevard
Suite 105
Lake Havasu City, AZ 86403
Phone: **1-928-453-5100**
Fax: **1-877-664-5264**
Toll-Free: **1-800-654-2076**

Phoenix ALTCS Office
801 East Jefferson Street, MD 1600
Phoenix, AZ 85034
Phone: **1-602-417-6600**
Fax: **1-602-253-6385**

Prescott ALTCS Office
Note: Prescott ALTCS staff are sharing space at the DES office.
3262 Bob Drive, Suite 11
Prescott Valley, AZ 86314
Phone: **1-928-778-3968**
Fax: **1-877-666-5269**
Toll-Free: **1-888-778-5600**

Sierra Vista ALTCS Office
Note: Sierra Vista ALTCS staff are sharing space at the DES office.

Street Address:
820 East Fry Blvd., Sierra Vista

Mailing address:
1010 North Finance Center, Suite 201
Tucson, AZ 85710

Phone: **1-520-459-7050**
Fax: **1-877-660-5342**
Toll-Free: **1-888-782-5827**

Tucson ALTCS Office
1010 North Finance Center Drive
Suite 201
Tucson, AZ 85710
Phone: **1-520-205-8600**
Fax: **1-877-666-5353**
Toll-Free: **1-800-824-2656**

Yuma ALTCS Office
3850 West 16th Street, Suite A
Yuma, AZ 85364
Phone: **1-928-782-0776**
Fax: **1-877-666-5382**
Toll-Free: **1-855-419-6527**

If your location is not listed, visit the AHCCCS website at **www.azahcccs.gov**.

Managed Care Definitions

Appeal: A formal complaint made where a member is not satisfied with a decision made by UnitedHealthcare Community Plan.

Copayment: A small charge or fee due at the time covered services are provided.

Durable medical equipment: Equipment that provides therapeutic benefits designed primarily for a medical purpose.

Emergency medical condition: A medical condition that's bad enough that a normal person could expect that without immediate medical attention would place the person's health in serious jeopardy.

Emergency medical transportation: Ambulance services for an emergency medical condition.

Emergency room care: Emergency services you get in an emergency room.

Emergency services: Services related to an emergency including room services and transportation regardless of the principal diagnosis on the emergency room and/or transportation claim.

Excluded services: Health care services that your health insurance or plan doesn't pay for or cover.

Grievance: A member's expression of dissatisfaction with any part of their care. A grievance can be filed over the phone or in writing. Grievances must be filed directly with UnitedHealthcare Community Plan, not AHCCCS.

Habilitation services and devices: Health care services that help you keep, learn, or improve skills and functioning for daily living.

Health insurance: Health insurance is a type of insurance coverage that pays for covered health services.

Home health care: Health care services a person receives at home.

Hospice services: Services to provide comfort and support for persons and their families in the last stages of a terminal illness.

Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires an overnight stay.

Hospital outpatient care: Care in a hospital that usually doesn't require an overnight stay.

Medically necessary: Health care or products that a prudent, or wise, doctor would give to a patient to prevent, diagnose, or treat an illness, injury, disease or its symptoms in a way that follows generally accepted standards for medicine and is not just for the convenience of the patient, physician or other health care provider.

Network: Doctors, specialists, hospitals, pharmacies and other providers who are contracted to provide health care services to UnitedHealthcare Community Plan members.

Non-participating provider: A provider who doesn't have a contract with your health insurer or plan to provide services to you.

Physician services: Health care services by a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine).

Plan: A benefit your insurer provides to you to pay for your health care services.

Preauthorization: Process by which your PCP or specialist contacts UnitedHealthcare Community Plan for approval to provide special services such as surgery.

Participating provider: A participating provider is a provider who has a contract with your health insurer or plan to provide services to you.

Premium: The amount you pay for your health insurance, usually each month.

Prescription drug coverage: Health insurance or plan that helps pay for prescription drugs and medications.

Prescription drugs: Drugs ordered by a doctor's written instructions.

Primary Care Physician: The doctor who treats the member directly. The PCP may refer the member to a specialist or admit the member to a hospital. PCPs are usually family practitioners, internists, pediatricians, and sometimes nurse practitioners and physician assistants, but may also include obstetricians and certified nurse midwives for pregnant members.

Primary Care Provider: An individual who meets the requirements of licensure by the State and who is responsible for the management of the member's health care.

Provider: A person or facility that provides health care services and treatment such as a doctor, pharmacy, dentist, clinic or hospital.

Rehabilitation services and devices: Health care services and devices that help you get back, or improve skills and functioning for daily living that have been lost or impaired because you were sick, hurt, or disabled.

Serious Mental Illness: A serious mental illness (SMI) is a mental disorder in persons 18 years of age or older that's severe and persistent. Persons who, as a result of a "mental disorder," exhibit emotional or behavioral functioning that is so impaired as to interfere substantially with their capacity to remain in the community without supportive treatment or services of a long-term or indefinite duration. In these persons, mental disability is severe and persistent, resulting in a long-term limitation of their functional capacities for primary activities of daily living such as interpersonal relationships, homemaking, self-care, employment and recreation.

Skilled nursing care: Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist: Any doctor who has special training for a specific condition or illness.

Urgent care: Care provided when a member's situation is not life-threatening, but member cannot wait 2 days (48 hours).

Maternity Care Service Definitions

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

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

Licensed Midwife means an individual licensed by the Arizona Department of Health Services to provide maternity care pursuant to Arizona Revised Statutes (A.R.S.) Title 36, Chapter 6, Article 7 and Arizona Administrative Code Title 9, Chapter 16 (this provider type does not include certified nurse midwives licensed by the Board of Nursing as a nurse practitioner in midwifery or physician assistants licensed by the Arizona Medical Board).

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

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

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

Postpartum care is the health care provided for a period of up to 60 days post-delivery. Family planning services are included, if provided by a physician or practitioner, as addressed in Policy 420 of the AHCCCS Medical Policy Manual.

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

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

a. Early and continuous risk assessment,

b. Health education and promotion, and

c. Medical monitoring, intervention, and follow-up.

UnitedHealthcare®
Community Plan

UnitedHealthcare Community Plan does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130

UHC_Civil_Rights@uhc.com

You must send the complaint within 60 calendar days of when you found out about it. A decision will be sent to you within 30 calendar days. If you disagree with the decision, you have 15 calendar days to ask us to look at it again.

If you need help with your complaint, please call Member Services at **1-800-293-3740**, **TTY 711**, Monday through Friday, 8:00 a.m. to 5:00 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online:
https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html

Phone:
Toll-free **1-800-368-1019**, **1-800-537-7697** (TDD)

Mail:
U.S. Dept. of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201

If you need help with your complaint, please call Member Services at **1-800-293-3740**, **TTY 711**.

Services to help you communicate with us are provided at no cost to members, such as other languages or large print. Or, you can ask for an interpreter. To ask for help, please call Member Services at **1-800-293-3740**, **TTY 711**, Monday through Friday, 8:00 a.m. to 5:00 p.m.

HEALTH PLAN NOTICES OF PRIVACY PRACTICES

THIS NOTICE SAYS HOW YOUR MEDICAL INFORMATION MAY BE USED. IT SAYS HOW YOU CAN ACCESS THIS INFORMATION. READ IT CAREFULLY.

Effective January 1, 2017.

By law, we[1] must protect the privacy of your health information ("HI"). We must send you this notice. It tells you:

- How we may use your HI.
- When we can share your HI with others.
- What rights you have to access your HI.

By law, we must follow the terms of this notice.

HI is information about your health or health care services. We have the right to change our privacy practices for handling HI. If we change them, we will notify you by mail or email. We will also post the new notice at this website **(www.uhccommunityplan.com)**. We will notify you of a breach of your HI. We collect and keep your HI to run our business. HI may be oral, written or electronic. We limit employee and service provider access to your HI. We have safeguards in place to protect your HI.

How We Use or Share Your Information
We must use and share your HI with:

- You or your legal representative.
- Government agencies.

We have the right to use and share your HI for certain purposes. This must be for your treatment, to pay for your care, or to run our business. We may use and share your HI as follows.

- **For Payment.** We may use or share your HI to process premium payments and claims. This may include coordinating benefits.
- **For Treatment or Managing Care.** We may share your HI with your providers to help with your care.
- **For Health Care Operations.** We may suggest a disease management or wellness program. We may study data to improve our services.
- **To Tell You about Health Programs or Products.** We may tell you about other treatments, products, and services. These activities may be limited by law.
- **For Plan Sponsors.** We may give enrollment, disenrollment, and summary HI to your employer. We may give them other HI if they properly limit its use.

- **For Underwriting Purposes.** We may use your HI to make underwriting decisions. We will not use your genetic HI for underwriting purposes.
- **For Reminders on Benefits or Care.** We may use your HI to send you appointment reminders and information about your health benefits.

We may use or share your HI as follows.

- **As Required by Law.**
- **To Persons Involved With Your Care.** This may be to a family member in an emergency. This may happen if you are unable to agree or object. If you are unable to object, we will use our best judgment. If permitted, after you pass away, we may share HI with family members or friends who helped with your care.
- **For Public Health Activities.** This may be to prevent disease outbreaks.
- **For Reporting Abuse, Neglect or Domestic Violence.** We may only share with entities allowed by law to get this HI. This may be a social or protective service agency.
- **For Health Oversight Activities** to an agency allowed by the law to get the HI. This may be for licensure, audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings.** To answer a court order or subpoena.
- **For Law Enforcement.** To find a missing person or report a crime.
- **For Threats to Health or Safety.** This may be to public health agencies or law enforcement. An example is in an emergency or disaster.
- **For Government Functions.** This may be for military and veteran use, national security, or the protective services.
- **For Workers' Compensation.** To comply with labor laws.
- **For Research.** To study disease or disability.
- **To Give Information on Decedents.** This may be to a coroner or medical examiner. To identify the deceased, find a cause of death, or as stated by law. We may give HI to funeral directors.
- **For Organ Transplant.** To help get, store or transplant organs, eyes or tissue.
- **To Correctional Institutions or Law Enforcement.** For persons in custody: (1) to give health care; (2) to protect your health and the health of others; and (3) for the security of the institution.
- **To Our Business Associates if needed to give you services.** Our associates agree to protect your HI. They are not allowed to use HI other than as allowed by our contract with them.

- **Other Restrictions.** Federal and state laws may further limit our use of the HI listed below.
  1. HIV/AIDS
  2. Mental health
  3. Genetic tests
  4. Alcohol and drug abuse
  5. Sexually transmitted diseases and reproductive health
  6. Child or adult abuse or neglect or sexual assault

We will follow stricter laws that apply. The attached "Federal and State Amendments" document describes those laws.

We will only use your HI as described here or with your written consent. We will get your written consent to share psychotherapy notes about you. We will get your written consent to sell your HI to other people. We will get your written consent to use your HI in certain promotional mailings. If you let us share your HI, the recipient may further share it. You may take back your consent. To find out how, call the phone number on your ID card.

Your Rights

You have the following rights.

- **To ask us to limit** use or sharing for treatment, payment, or health care operations. You can ask to limit sharing with family members or others. We may allow your dependents to ask for limits. **We will try to honor your request, but we do not have to do so.**
- **To ask to get confidential communications** in a different way or place. For example, at a P.O. Box instead of your home. We will agree to your request when a disclosure could endanger you. We take verbal requests. You can change your request. This must be in writing. Mail it to the address below.
- **To see or get a copy** of certain HI. You must ask in writing. Mail it to the address below. If we keep these records in electronic form, you can request an electronic copy. You can have your record sent to a third party. We may send you a summary. We may charge for copies. We may deny your request. If we deny your request, you may have the denial reviewed.
- **To ask to amend.** If you think your HI is wrong or incomplete, you can ask to change it. You must ask in writing. You must give the reasons for the change. Mail this to the address below. If we deny your request, you may add your disagreement to your HI.
- **To get an accounting** of HI shared in the six years prior to your request. This will not include any HI shared for the following reasons: (i) For treatment, payment, and health care operations; (ii) With you or with your consent; (iii) With correctional institutions or law enforcement. This will not list the disclosures that federal law does not require us to track.
- **To get a paper copy of this notice.** You may ask for a paper copy at any time. You may also get a copy at our website **(www.uhccommunityplan.com)**.

Using Your Rights

- **To Contact your Health Plan. Call the phone number on your ID card.** Or you may contact the UnitedHealth Group Call Center at **1-866-633-2446**, or **TTY 711**.
- **To Submit a Written Request.** Mail to:

  UnitedHealthcare Privacy Office
  MN017-E300
  P.O. Box 1459
  Minneapolis, MN 55440
- **To File a Complaint.** If you think your privacy rights have been violated, you may send a complaint at the address above.

You may also notify the Secretary of the U.S. Department of Health and Human Services. We will not take any action against you for filing a complaint.

[1] This Medical Information Notice of Privacy Practices applies to the following health plans that are affiliated with UnitedHealth Group: AmeriChoice of New Jersey, Inc.; Arizona Physicians IPA, Inc.; Health Plan of Nevada, Inc.; Unison Health Plan of Delaware, Inc.; UnitedHealthcare Community Plan of Ohio, Inc.; UnitedHealthcare Community Plan of Texas, L.L.C.; UnitedHealthcare Community Plan, Inc.; UnitedHealthcare Insurance Company; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Louisiana, Inc.; UnitedHealthcare of the Mid-Atlantic, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; United Healthcare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Mexico, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of Pennsylvania, Inc.; UnitedHealthcare of Washington, Inc.; UnitedHealthcare of Wisconsin, Inc.; UnitedHealthcare Plan of the River Valley, Inc.

Financial Information Privacy Notice

THIS NOTICE SAYS HOW YOUR FINANCIAL INFORMATION MAY BE USED AND SHARED. REVIEW IT CAREFULLY.

Effective January 1, 2017.

We[2] protect your "personal financial information" ("FI"). FI is non-health information. FI identifies you and is generally not public.

Information We Collect

- We get FI from your applications or forms. This may be name, address, age and social security number.
- We get FI from your transactions with us or others. This may be premium payment data.

Sharing of FI

We will only share FI as permitted by law.

We may share your FI to run our business. We may share your FI with our Affiliates. We do not need your consent to do so.

- We may share your FI to process transactions.
- We may share your FI to maintain your account(s).
- We may share your FI to respond to court orders and legal investigations.
- We may share your FI with companies that prepare our marketing materials.

Confidentiality and Security

We limit employee and service provider access to your FI. We have safeguards in place to protect your FI.

Questions About This Notice
Please **call the toll-free member phone number on your health plan ID card** or contact the UnitedHealth Group Customer Call Center at **1-866-633-2446**, or **TTY 711**.

[2] For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed in footnote 1, beginning on the last page of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: Alere Women's and Children's Health, LLC; AmeriChoice Health Services, Inc.; Connextions HCI, LLC; Dental Benefit Providers, Inc.; gethealthinsurance.com Agency, Inc.; Golden Outlook, Inc.; HealthAllies, Inc.; LifePrint East, Inc.; Life Print Health, Inc.; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; OneNet PPO, LLC; OptumHealth Care Solutions, Inc.; OrthoNet, LLC; OrthoNet of the Mid-Atlantic, Inc.; OrthoNet West, LLC; OrthoNet of the South, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; Spectera, Inc.; UMR, Inc.; Unison Administrative Services, LLC; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Services LLC; UnitedHealthcare Services Company of the River Valley, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to (1) health care insurance products offered in Nevada by Health Plan of Nevada, Inc. and Sierra Health and Life Insurance Company, Inc.; or (2) other UnitedHealth Group health plans in states that provide exceptions.

UNITEDHEALTH GROUP HEALTH PLAN NOTICE OF PRIVACY PRACTICES: FEDERAL AND STATE AMENDMENTS

Revised: January 1, 2017.

The first part of this Notice (pages 86 – 89) says how we may use and share your health information ("HI") under federal privacy rules. Other laws may limit these rights. The charts below:

1. Show the categories subject to stricter laws.
2. Give you a summary of when we can use and share your HI without your consent.

Your written consent, if needed, must meet the rules of the federal or state law that applies.

SUMMARY OF FEDERAL LAWS

Alcohol and Drug Abuse Information
We are allowed to use and disclose alcohol and drug abuse information that is protected by federal law only (1) in certain limited circumstances, and/or disclose only (2) to specific recipients.

Genetic Information
We are not allowed to use genetic information for underwriting purposes.

SUMMARY OF STATE LAWS

General Health Information	
We are allowed to disclose general health information only (1) under certain limited circumstances, and/or (2) to specific recipients.	AR, CA, DE, NE, NY, PR, RI, VT, WA, WI
HMOs must give enrollees an opportunity to approve or refuse disclosures, subject to certain exceptions.	KY
You may be able to restrict certain electronic disclosures of health information.	NC, NV
We are not allowed to use health information for certain purposes.	CA, IA
We will not use and/or disclose information regarding certain public assistance programs except for certain purposes.	KY, MO, NJ, SD
We must comply with additional restrictions prior to using or disclosing your health information for certain purposes.	KS

Prescriptions	
We are allowed to disclose prescription-related information only (1) under certain limited circumstances, and/or (2) to specific recipients.	ID, NH, NV
Communicable Diseases	
We are allowed to disclose communicable disease information only (1) under certain limited circumstances, and/or (2) to specific recipients.	AZ, IN, KS, MI, NV, OK
Sexually Transmitted Diseases and Reproductive Health	
We are allowed to disclose sexually transmitted disease and/or reproductive health information only (1) under certain limited circumstances and/or (2) to specific recipients.	CA, FL, IN, KS, MI, MT, NJ, NV, PR, WA, WY
Alcohol and Drug Abuse	
We are allowed to use and disclose alcohol and drug abuse information (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	AR, CT, GA, KY, IL, IN, IA, LA, MN, NC, NH, OH, WA, WI
Disclosures of alcohol and drug abuse information may be restricted by the individual who is the subject of the information.	WA
Genetic Information	
We are not allowed to disclose genetic information without your written consent.	CA, CO, KS, KY, LA, NY, RI, TN, WY
We are allowed to disclose genetic information only (1) under certain limited circumstances and/or (2) to specific recipients.	AK, AZ, FL, GA, IA, IL, MD, MA, ME, MO, NJ, NV, NH, NM, OR, RI, TX, UT, VT
Restrictions apply to (1) the use, and/or (2) the retention of genetic information.	FL, GA, IA, LA, MD, NM, OH, UT, VA, VT

HIV/AIDS	
We are allowed to disclose HIV/AIDS-related information only (1) under certain limited circumstances and/or (2) to specific recipients.	AZ, AR, CA, CT, DE, FL, GA, IA, IL, IN, KS, KY, ME, MI, MO, MT, NY, NC, NH, NM, NV, OR, PA, PR, RI, TX, VT, WV, WA, WI, WY
Certain restrictions apply to oral disclosures of HIV/AIDS-related information.	CT, FL
We will collect certain HIV/AIDS-related information only with your written consent.	OR
Mental Health	
We are allowed to disclose mental health information only (1) under certain limited circumstances and/or (2) to specific recipients.	CA, CT, DC, IA, IL, IN, KY, MA, MI, NC, NM, PR, TN, WA, WI
Disclosures may be restricted by the individual who is the subject of the information.	WA
Certain restrictions apply to oral disclosures of mental health information.	CT
Certain restrictions apply to the use of mental health information.	ME
Child or Adult Abuse	
We are allowed to use and disclose child and/or adult abuse information only (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	AL, CO, IL, LA, MD, NE, NJ, NM, NY, RI, TN, TX, UT, WI

We're here for you.

Remember, we're always ready to answer any questions you may have. Just call Member Services at **1-800-293-3740**, **TTY 711**. You can also visit our website at **UHCCommunityPlan.com**.

UnitedHealthcare Community Plan
1 East Washington, Suite 800
Phoenix, AZ 85004

UHCCommunityPlan.com

1-800-293-3740, **TTY 711**

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