



Welcome to the community

Long Term Care Member Handbook

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**United
Healthcare
Community Plan**

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2 **Questions?** Visit [UHCCommunityPlan.com](https://www.uhc.com/communityplan),
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Important information

Member Services **1-800-293-3740, TTY 711**
8:00 a.m. – 5:00 p.m. Arizona time, Monday – Friday
After-hours **1-800-377-2055, option 1**

In case of emergency dial 911

Your health providers

Be sure to fill in the blanks so you will have these numbers ready.

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 doctor's address: _____

My dentist: _____

Pharmacy: _____

Behavioral health providers: _____

Behavioral health crisis: _____

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 in advance (excluding weekends and holidays)
to make a reservation, but not more than 2 weeks before your
scheduled appointment.

Case Manager 1-800-293-3740, TTY 711

Your Case Manager helps set up services for you and will help you
with any behavioral health, medical or social service needs. If you
do not have your case manager’s name or phone number, contact
Member Services.

Medical management/prior authorization 1-800-293-3740, TTY 711

Providers may be required to get approval before a service is rendered.
If you have questions about this process or the authorization, contact
your Case Manager or Member Services.

Dental 1-800-293-3740, TTY 711

If you need help with understanding benefits, or information
on available dental providers, contact your Case Manager
or Member Services. You may also find benefit information
and dental providers online at: myuhc.com/CommunityPlan

NurseLine 1-877-440-0255, TTY 1-800-855-2880

Get 24/7 health advice from a nurse (toll-free)

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:

- Answer questions about your physical and behavioral health benefits.
- Help solve a problem or concern you might have with your doctor or any part of the health plan.
- Help you find a doctor or dentist.
- Tell you about our doctors, their backgrounds, and the care facilities in our network.
- Help you if you get a medical bill.
- Tell you about community resources available to you.
- Help you if you speak another language, are visually impaired, need interpreter services, or sign language services.
- How to contact your Case Manager.
- Help answer other questions you may have.
- Provide you with a copy of the Member Handbook at no cost to you.

Questions? Visit [UHCCommunityPlan.com](https://www.uhc.com/community-plan), 7
or call Member Services at **1-800-348-4058**, TTY 711.

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Long Term Care Member Handbook

Member Services is here to help you

Call **1-800-293-3740**, TTY **711**, 8:00 a.m. – 5:00 p.m., Arizona time, Monday – Friday, excluding state holidays.

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

When you call us ...

We ask questions to check your identity. We do this to protect your privacy. This is federal and state law. Gather the following information before you call:

- Member ID number.
- Current address and phone number on file with AHCCCS.
- Date of birth.

Member Services is here to help you

Call **1-800-293-3740**, TTY **711**, 8:00 a.m. – 5:00 p.m. Arizona time, Monday – Friday, excluding state holidays. After-hours **1-800-377-2055, option 1**.

NurseLine (available 24 hours per day/7 days a week) **1-877-440-0255**
TTY/TDD **1-800-855-2880**

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.

8 **Questions?** Visit UHCCommunityPlan.com,
or call Member Services at **1-800-348-4058**, TTY **711**.

- How to find a prescription drug.
- 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.

Health4Me™

Health4Me™ Mobile app

This no cost mobile app allows you to access key information on the go. You can search for nearby doctors, view your Member Handbook or view your member ID card.

The Health4Me mobile app can be downloaded to an Apple® or Android® smartphone or tablet.

MyCaregiver

Caring for a loved one can be rewarding. But it can also be very challenging. Now there's an easy-to-use online tool called MyCaregiver that helps make it a little less stressful. You can now store all of your caregiving information in one place.

How MyCaregiver works:

- **Register online** and create your personalized account. Resources and articles are offered based on your needs. Save the ones you like as favorites.
- **Start tracking information.** Track doctor appointments, daily medication reminders and communicate tasks or updates to your care circle through the message board.
- **Create a circle of care.** Invite family and friends to share updates and daily responsibilities.

If you have any questions or issues, an experienced case manager is just a phone call away. Register for MyCaregiver today. Visit UHCCommunityPlan.com/AZcaregivers.

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

What if I am experiencing a Behavioral Health Crisis?

If you are experiencing a behavioral health crisis, it is important to get help right away. Remember, you should always call **911** if you are experiencing a medical, police and/or fire emergency situation.

Crisis hotlines:

If you are experiencing a behavioral health crisis call one of the phone numbers below that matches the county you live in. Crisis hotlines are available 24 hours a day, 7 days a week, 365 days per year. Crisis calls are answered by a live trained crisis specialist. These crisis hotlines will provide access to 24/7 mobile crisis intervention and facility based 23-hour crisis stabilization centers, including detox/medication assisted treatment. Crisis services are available to all Arizonans and is not dependent on Medicaid status and health insurance coverage.

Crisis hotlines by county:

Phone:

Maricopa County	602-222-9444 or 1-800-631-1314
Cochise, Graham, Greenlee, La Paz, Pima, Pinal, Santa Cruz and Yuma Counties	1-866-495-6735
Apache, Coconino, Gila, Mohave, Navajo and Yavapai Counties	1-877-756-4090
Gila River and Ak-Chin Indian Communities	1-800-259-3449
Salt River Pima Maricopa Indian Community	1-855-331-6432

Especially for teens:

Teen lifeline phone or text	602-248-TEEN (8336)
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National 24-hour crisis hotlines:

Phone:

National suicide prevention lifeline	1-800-273-TALK (8255)
National substance use and disorder issues Referral and treatment hotline	1-800-662-HELP (4357)

Text:

Text the word	“HOME” to 741741
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Chat	https://suicidepreventionlifeline.org/chat
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Senior Help Line: 24-hour senior help line	602-264-4357
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Online	https://suicidepreventionlifeline.org
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Questions? Visit UHCommunityPlan.com, 11
or call Member Services at **1-800-348-4058**, TTY 711.

Long Term Care Member Handbook

Trans Lifeline:

A peer-support crisis hotline in which all operators are transgender 1-877-565-8860
Online www.translifeline.org

Veterans crisis line/Be Connected line:

Veterans resources (and for those who support them) 1-866-4AZ-VETS or 1-866-429-8387

Warm Line:

The Warm Line is a free and confidential telephone service staffed by peers who have, themselves, dealt with behavioral health challenges. Peer support specialists can relate to behavioral health situations because many have been through similar experiences. Peer support specialists offer peer support and compassion for callers who just need someone to talk with. Available 24 hours a day 7 days a week. This is available statewide. Members can call any number listed below:

Maricopa County 602-347-1100
Pima County 520-770-9909
Southern Arizona Counties 844-733-9912
Northern Arizona Counties 888-404-5530

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 <https://www.uhccommunityplan.com/az/medicaid/long-term-care.html>.

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: <https://www.uhccommunityplan.com/az/medicaid/long-term-care.html>.

If you choose to see a provider who is not contracted with UnitedHealthcare Community Plan, you will need to verify the provider is registered with AHCCCS, show the provider your ID card, and make sure the provider obtains an authorization for services to be performed. For services to be paid, the provider must be registered with AHCCCS and authorization must be obtained by the provider from us.

Members can receive a paper copy of the provider directory, at no cost, by contacting Member Services at **1-800-293-3740**, 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 Practitioner. 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.

ID card

When you join our plan, you will receive an ID card from UnitedHealthcare Community Plan. Your ID card is your key to getting health care services including behavioral health. It has your ID number, your name, and other important information. Your ID card identifies you as a UnitedHealthcare Community Plan member.

Your ID card has a phone number to access behavioral health and substance use services. Services are assigned to a provider based on where you live. If you have questions or need help getting behavioral health services, please call the number on your card.

When you get your card, check it carefully. Call Member Services right away if any of the information on your card is wrong. Member Services can be reached by calling **1-800-293-3740**, TTY **711**.

Quick tips

- Your ID card is for your use only. Don't let others use it.
- Carry your ID card at all times and keep it in a safe place.
- Do not lose your card or throw it away.
- You will need your card when you get medical care or when you pick up medicine at the pharmacy.
- Misusing your medical ID number, like loaning or selling the card or the information on it, is against the law.
- Misusing your card or medical ID number may result in legal actions and you could lose your AHCCCS eligibility, benefits and health care services.
- If you notice others getting benefits they are not eligible for or someone misusing the medical ID card, please tell us right away. You can call or write AHCCCS or UnitedHealthcare Community Plan Member Services. AHCCCS also has a Member Fraud Hotline you can call at 1-888-ITS NOT OK (1-888-487-6686) or 602-417-4193.
- You may also call AHCCCS or UnitedHealthcare Community Plan to report any provider you believe may be giving services to members that are not needed or should not be given.
- If you have an Arizona driver's license or state issued ID, AHCCCS will obtain your picture from the Arizona Department of Transportation Motor Vehicle Division (MVD). The AHCCCS eligibility verification screen viewed by providers contains your picture (if available) and coverage details.

Do not throw away your ID card.

Sample card

 Health Plan (80840) 911-03432-06	
Member ID: 9999993042	Group: AZLTC
Member: REISSUE S ENGLISH	Long Term Care
Member Services: (800) 293-3740 Behavioral Services: (800) 293-3740 After Hours Member Services: (800) 377-2055	Rx Bin: 610494 Rx Grp: ACUAZ Rx PCN: 4100
Member Identification Card ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM	

Front

Printed: 10/30/19	
Carry this card with you at all times. Present it when you get service. You may be asked for a picture ID. Using the card inappropriately is a violation of law. This card is not a guarantee for services. To verify benefits visit myUHC.com/CommunityPlan .	
Member Services: NurseLine:	1-800-293-3740 TTY/TDD 711 1-877-440-0255
For Providers: Claims: Notification:	UHCprovider.com PO Box 5290, Kingston, NY, 12402-5290 1-800-377-2055 Eligibility: 1-800-293-3740
Pharmacy Claims: OptumRX, PO Box 650334, Dallas, TX 75265-0334 For Pharmacists: 877-305-8952	

Back

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.
- 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.
- Be in charge of my planning meeting.
- Ask anyone I want to come to my planning meetings.
- Choose my goals to work on and what is on my plan.
- Schedule my person-centered planning meeting at a time and place when the people who I want to attend are available.
- Agree to the services I want from the choice of services I can have.
- Pick an available provider I want to give me my services.
- Know that I may need help from my guardian, family and/or friends to make good choices.

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.

“Healthier lives. Healthier you.”

- 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. Which includes, refraining from use of disparaging remarks, racial or ethnic slurs, profanity towards providers, caregivers and/or Case Managers are not acceptable.

Not to ask your Case Manager to:

- Provide hands on care.
- Move any of your belongings.
- Drive you in their car.
- Lend you money.
- Sign forms or paperwork for you.

In the presence of your Case Manager you cannot: use drugs, drink alcohol, display firearms, make sexual advances or disrobe.

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 Long Term Care, you will need to change your health plan. Your change needs to be communicated to your Case Manager in writing or verbally. 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, report your absence or trip to your Case Manager. When you are outside your service area, UnitedHealthcare Community Plan only pays for emergency care. If you have an emergency, go to the nearest emergency room or hospital. Tell them you are a member of UnitedHealthcare Community Plan or show your ID Card. Any service you get that is not an emergency will not be covered by UnitedHealthcare Community Plan. You may be charged for services that are not an emergency. If you need care, but it is not an emergency, call your PCP or Member Services. UnitedHealthcare Community Plan will not pay for any services received outside of the country including emergency care.

Changes in information

Changes you must report to your Case Manager include:

- Adoption.
- Marriage.
- Birth.
- Moving to a new county.
- Death.
- Divorce.
- Moving to a new state.
- Guardianship.
- Address.
- Phone number.

Changing plans

Every year if you reside in Maricopa, Pinal or Gila counties, you have the option to change plans during Annual Enrollment Choice (AEC). This is the date you enrolled with AHCCCS. AHCCCS will send you a notice two months before the date you can change. If you want to change health plans, call UnitedHealthcare Community Plan Member Services. We want to help with any problems you have first.

If you want to change health plans and it is not your AEC period, you may still be able to change plans in special cases. You may be able to change your health plan if:

- 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 and Gila 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.

ALTCS transitional program

A transitional program is for members who do not meet nursing home level of care according to ALTCS eligibility requirements, 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 up to 25 days per year (October 1 – September 30) 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 by moving from a FFS plan to an MCO, an MCO to a different MCO, or an MCO to a FFS plan 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.

Treatment planning

Case Management assesses, plans, coordinates, and monitors options and services to meet the health needs of the member through communication and available resources to promote quality and cost-effective outcomes. It includes a review of the member's strengths and needs by the member, his/her family or representative with the Case Manager so they can make informed decisions. Case management respects the preferences, interests, needs, culture, language and belief system of the member and his/her family/representative. The Case Manager ensures the member and family/representative are partners in the treatment planning process and development of the service plan. This partnership is expected to result in a mutually agreed upon service plan that meets the medical, functional, social and behavioral health needs of the member.

Emergency care

An emergency is a sickness that is sudden and puts your life in danger or can cause harm to you if not treated right away. In an emergency, it is very important to get care right away.

If you have an emergency, call 911 or go to the nearest emergency room.

Preauthorization is not required for emergency care. You have the right to go to any hospital emergency room or other setting for emergency services, such as an urgent care center when your doctor's office is closed.

Not all health problems are an emergency. Some reasons to call 911 or go to the emergency room include:

- Sudden loss of feeling, or not being able to move.
- Chest pain.
- Severe pain in your stomach area.
- Poisoning.
- A serious accident.
- Severe shortness of breath.
- Severe burns.
- Severe wound or heavy bleeding.
- Damage to your eyes.
- Severe spasms/convulsions.
- Broken bones.
- Choking or being unable to breathe.
- Throwing up (vomiting) blood.
- Strong feeling that you might hurt yourself or another person.
- Faint or pass out for no reason (will not wake up).
- Danger of losing life or limb.
- Loss of speech.
- Assault.

If you are not sure it's a real emergency or if you have questions about whether your situation requires treatment in an urgent care center or an emergency room, call your PCP or NurseLine at 1-877-440-0255, TTY/TDD 1-800-855-2880. NurseLine is available 24 hours per day/7 days a week.

If you do go to an emergency room, show ALL ID cards when you arrive. Call your PCP and Case Manager within 2 days/48 hours, or as soon as possible. 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. 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.

When not to use the emergency room

Most sicknesses are not emergencies and can be treated at your doctor's office. You can also be treated at an Urgent Care site. You should not use an emergency room if you have one of these minor problems:

- A sprain or strain.
- A cut or scrape.
- An earache.
- A sore throat.
- A cough or cold.

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)

If you need a ride to an appointment, ask a friend, family member or neighbor first. If you cannot get a ride, UnitedHealthcare Community Plan will help you. Members may receive non-emergency transportation services through UnitedHealthcare Community Plan for AHCCCS covered services. You are responsible for setting up your own transportation. Members and/or family representatives are able to schedule non-emergency transportation. There is no additional authorization necessary.

Following these simple rules will help you get a ride:

- Call at least 72 hours before your health care visit.
- Call **1-888-700-6822** or **602-889-1777**, TTY/TDD **711** to set up your ride.
- If you cancel your visit, call **1-888-700-6822** or **602-889-1777** to cancel your ride.
- Rides are only for covered services.
- Know the address of your health care provider.
- Be specific about where you need a ride to.
- After your visit, call for a ride home.
- Let us know if you have special needs like a wheelchair.
- Members 14 years of age and younger must have a parent or guardian with them. Members between the ages of 15 and 17 must be accompanied by a parent or guardian unless MTBA has received a signed waiver of consent from the member's parent or guardian.
- Transportation may be limited to a provider near you.

If you need transportation to an **Urgent Care center**, you may call at any time, any day of the week. You do not need to give advance notice for urgent care transportation.

Transportation is available to local community based support programs if documented in your service plan with your behavioral health provider. Transportation is limited to transporting you to the nearest program capable of meeting your needs. For more information contact your behavioral health provider.

If you have a life-threatening emergency, call 911. Non-emergent transportation is not for emergencies.

Covered health care services

These are many of the Long Term Care covered services you can receive if they are medically necessary. Your PCP or primary specialist will help you decide if you need them. If you receive services that are not covered by Long Term Care, you may be required to pay for them.

Covered Service

Adaptive aids.

Bariatric surgery.

Behavioral health services.

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 <https://www.uhccommunityplan.com/az/medicaid/long-term-care.html> 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).

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Covered Service

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.

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.

Transplantation of organs and tissue and related medications covered for members with specified medical conditions.

- Transplant services and medications when medically necessary, must be pre-authorized.
- Transplants must be done at an AHCCCS approved transplant center.

Covered Service

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.

Routine and emergency eyecare and all necessary vision examinations, prescriptive lenses, frames, and treatments for conditions of the eye for all members under the age of 21.

Services previously covered by Children's Rehabilitative Services.

Telehealth visits over the phone or video.

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. EPSDT visits for members under 21 years of age are considered the same as a well visit.

Dental care – Routine and emergency dental care for members under the age of 21

Dental care – Limited medical and surgical services by a dentist for members 21 years of age and older.

Dental care – 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 care – Routine, preventive, and therapeutic 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.

Covered Service

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).

Genetic testing and counseling when considered medically necessary.

Lung volume reduction surgery (LVRS): LVRS, or reductive pneumoplasty is covered for persons with severe emphysema, covered when medically necessary.

Prosthetic devices when medically necessary.

Covered Service

Therapies Covered for Members Who Are 21 Years of Age and Older

Occupational therapy inpatient/outpatient.

Covered when medically necessary.

Physical therapy inpatient.

Covered when medically necessary.

Physical therapy outpatient.

- 15 visits per benefit year (October 1 – September 30) to restore a skill or function the member had but lost due to injury or disease and maintain that function once restored; and
- 15 visits per benefit year (October 1 – September 30) to reach or obtain a skill or function never learned or developed and maintain that function once developed.

Speech therapy inpatient/outpatient.

Covered when medically necessary.

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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). If you are living in a nursing home, you pay your “share of cost” to the home. ALTCS will tell you your “member share of cost.”
- 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.)
- If you are in an assisted living facility, you must pay for your room and board. You pay this directly to your facility.
- Adult foster care. (ALTCS HCBS approved with services on a continuing basis for four or fewer people.)
- Behavioral health residential facility.
- Traumatic brain injury Assisted Living 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. Up to 600 respite hours per benefit year (October 1 – September 30) are available.
- Group respite as alternative to adult day health.
- Attendant care models of care.
 - Parents may provide attendant care services if the member is 18 years of age or older. Contact your Case Manager for more information.
 - Attendant care services are not reimbursable in any inpatient, institutional, or alternative home and community based setting.
 - 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.
 - Traditional attendant care.
- 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 a provider who is not registered with AHCCCS.
- Services that are not medically necessary.
- 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 that are determined to be experimental by the health plan Medical Director.
- Services that are not the least costly service with the same result.
- 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.
- Medical Marijuana – AHCCCS does not cover medical marijuana as a medical or pharmacy benefit.
- Medical services for those in an institution for TB (tuberculosis) treatment.
- Over-the-counter medicines and medical supplies (except under certain conditions).
- Personal care items such as combs, razors, soap, etc.
- Prescriptions not on our list of covered medications, unless approved.
- Routine eye examinations for prescriptive lenses or glasses for adults 21 and over.

The following are not covered for the purpose of 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.

Housing services

Your Case Manager can assist you in finding local low-income housing that is available utilizing our Program Housing Coordinator. Members can obtain information about housing resources and referrals by contacting their Case Manager or Member Services.

For members with a Serious Mental Illness (SMI) there are Non-Title XIX/XXI 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.

32 **Questions?** Visit UHCommunityPlan.com, or call Member Services at **1-800-348-4058**, TTY **711**.

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. All settings must be integrated in and support access to the greater community. 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 Behavioral Health Therapeutic Home: Licensed by Arizona Department of Health Services (ADHS). A behavioral health supportive home that provides room and board, assists in acquiring daily living skills, coordinates transportation to scheduled appointments, monitors behaviors, assists in the self-administration of medication, and provides feedback to case manager related to behavior for an individual 18 years of age or older based on the individual's behavioral health issues and need for behavioral health services.

Behavioral Health Residential Facility: Licensed by Arizona Department of Health Services (ADHS). An HCB alternative residential behavioral health treatment setting that provides treatment to an individual experiencing a behavioral health issue that: Limits the individual's ability to be independent, or causes the individual to require treatment to maintain or enhance independence.

Behavioral Health Respite Homes: Licensed by Arizona Department of Health Services (ADHS) as a behavioral health residential facility that is qualified to provide respite services.

Substance Abuse Transitional Facility: Licensed by Arizona Department of Health Services (ADHS). A health care institution that provides behavioral health services to an individual who is intoxicated or who may have a substance abuse problem.

End of Life care

End of Life (EOL) care is a member-centered approach with the goal of preserving the member's rights and maintaining dignity while receiving any other medically necessary covered services. End of Life care focuses on comfort and quality of life for the member, at any stage of an illness. 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 is in charge of ALL your covered health care needs. If you need specialty care, your PCP may refer you to a specialist or another doctor.

Members may also request services without a referral and may choose a provider from UnitedHealthcare Community plan's provider network.

For urgent specialty care appointments member will be seen no later than 2 business days from the request and routine care appointments are within 45 calendar days of the request.

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.

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 during the assessment process. Person-Centered Service Planning is for Case Managers, members and their family, friends, Health Care Decision Makers and caregivers to work together to create and implement a service plan **driven by you and addressing what is important to and for the member**. This process:

- Builds on member's strengths, life preferences, and support need.
- Includes opportunities for meaningful activities such as social connections, employment, community activities and volunteering.
- Promotes independence and community inclusion.

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.
- Obtain Behavioral Health Services.

Visit our website or contact Member Services to obtain a copy of the UnitedHealthcare Community Plan Provider Directory at no cost to you. Our directory contains information about how our providers can meet your cultural, language, or accessibility needs.

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 **1-800-293-3740, 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. Indian Health Service Provider may refer the member to a UnitedHealthcare Community Plan provider.

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 may choose a Primary Care OB (obstetrician), primary care physician or primary care practitioner such as a nurse practitioner, physician's assistant, or midwife. These maternity and family planning providers will ensure you get pre- and postpartum services. 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 medications 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 <https://www.uhcommunityplan.com/az/medicaid/long-term-care.html>. 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

Urgent Care:	Appointments are to be scheduled as soon as the member's health condition require, but no later than 2 business days of request.
Routine Care:	Within 21 calendar days of the request.

Specialist appointments, including dental specialty appointments

Urgent Care:	Appointments are to be scheduled as soon as the member's health condition require, but no later than 2 business days from the request.
Routine Care:	Within 45 calendar days of the request.

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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. EPSDT visits for members under 21 years of age are considered the same as a well visit.

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** — Asthma, 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 mental health problems for AHCCCS members under the age of 21.

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

EPSDT services provide comprehensive health care through primary prevention, early intervention, diagnosis, medically necessary treatment, and follow-up care of physical and behavioral health problems for AHCCCS members less than 21 years of age. EPSDT services include screening services, vision services, dental services, hearing services and all other medically necessary mandatory and optional services listed in federal law 42 U.S.C. 1396d(a) to correct or ameliorate defects and physical and mental illnesses and conditions identified in an EPSDT screening whether or not the services are covered under the AHCCCS state plan. Limitations and exclusions, other than the requirement for medical necessity and cost effectiveness do not apply to EPSDT services.

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

Amount, duration and scope:

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

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

EPSDT includes, but is not limited to, coverage of:

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

Women's health and pregnancy services

UnitedHealthcare Community Plan knows that healthy moms have healthy babies. That is why we take special care of all our moms-to-be. 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.

Female members, or members assigned female at birth, 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.

As a member, UnitedHealthcare Community Plan will help you:

- Choose a Primary Care Obstetrician (PCO), nurse practitioner, physician assistant, or Certified Nurse Midwife (CNM) for pregnancy care.
- Get information about Healthy First Steps — a maternity program for you and your baby. You can call Healthy First Steps at 1-800-599-5985.
- Access the Maternal Child Health Home Visiting Programs for pregnant women and families with children birth to age 5. There is no cost and a trained home visitor comes to the home to help families with education on topics such as: parenting, breastfeeding, employment and child care solutions, child abuse/child neglect prevention, child development, and school readiness.
- Schedule appointments and exams.
- Choose a pediatrician (child's doctor) for your new baby.
- Choose a PCP for you after the birth or return to the PCP you had before your pregnancy. Call Member Services after your delivery.
- Get information on community programs such as WIC (Women, Infants, and Children). You can call WIC at 1-800-252-5942.

- Get information on community programs such as Children’s Information Center for car seats, child care, breastfeeding, and other resources. You can call the Office for Children with Special Health Care Needs at 1-800-232-1676 or OCSHCN@azdhs.gov.
- Get answers to your breastfeeding questions 24 hours a day by calling the Arizona Department of Health Services’ 24-Hour Breastfeeding Hotline at 1-800-833-4642 or by visiting www.gobreastmilk.org.

Your doctor will give you:

- Care before and after your baby is born (no copayments).
- Information about having a healthy pregnancy, such as good nutrition, quitting smoking, and exercise.
- Information about childbirth options and childbirth classes.
- Help with family planning choices and services after your baby’s birth (including but not limited to birth control pills, condoms, and sterilizations).

Prenatal care appointment time frames

- First Trimester – Within 14 calendar days of request for appointment.
- Second Trimester – Within 7 calendar days of request for appointment.
- Third Trimester – Within 3 business days of request for appointment.
- High-Risk Pregnancy – Appointments are to be scheduled as soon as the member’s health condition require, but no later than 3 business days of identification of high risk by UHCCP or a maternity care provider, or immediately if an emergency exists.

Your appointments are very important to your health and the health of your baby. You should see your doctor during pregnancy even if you feel good. If you need to change your appointment, contact your doctor before your appointment. You should also see your doctor within 57 days after your baby’s birth (postpartum care). 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 condition.
- Answer questions about breastfeeding and examine your breasts.
- Address questions about having sex again and birth control options.

You can have an HIV test at anytime. If your test is positive, you can get specialty treatment and medical counseling. Talk to your PCP or contact your local department of public health for testing.

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If you are pregnant and you have been seeing a doctor that is not in our network, you may be able to change plans. This is because you may have a medical continuity of care issue during your pregnancy. Please see “Changing Plans” earlier in this handbook.

If you find out you are no longer pregnant, call your Case Manager or Member Services. They will help you arrange any health care services or changes you may need.

If you have questions or need help getting behavioral health services, please call your Case Manager the number on your ID card. Please see page 11 of this handbook for behavioral health crisis information and pages 49 – 56 for additional information about behavioral health services.

Substance Use Disorder Helpline: 855-780-5955

The Substance Use Disorder Helpline is a **free, anonymous** resource for pregnant women and women in their **postpartum period** (up to one year) who are seeking help for themselves or a loved one who need help with Substance Use Disorder, Alcohol Use Disorder, or Opiate Use Disorder.

The Substance Use Disorder Helpline is available **24 hours a day, 7 days a week** and offers direct access to a licensed Behavioral Health Clinician/Specialized Substance Use Recovery Advocate (SURA) who can provide assistance and provider referrals. Substance use disorders occur when the recurrent use of alcohol, tobacco, or drugs (including opioids, marijuana, stimulants, and hallucinogens) causes significant impairment – such as health problems, disability, and failure to meet major responsibilities at work, school, or home.

Some examples of when to call the Substance Use Disorder Helpline:

- You may be using substances inappropriately and are at risk of abuse or addiction.
- You are looking for help, but are too embarrassed to ask for it.
- You have concerns about your substance use, or the substance use of a friend or loved one.
- You have questions about the treatment of addiction, and what your insurance plan will cover.
- You are seeking providers who specialize in the treatment of substance use disorders.

Substance Use Disorder is a disease

Those suffering from any form of Substance Use Disorder need emotional support, empathy, and evidence-based treatment in order to recover – just like any other serious illness.

Family planning services

For Family planning services, you may choose a primary care physician or primary care practitioner such as a nurse practitioner, physician's assistant, or midwife. Women may also see an OB/GYN to receive these services without a referral from their PCP. The OB/GYN must be contracted with UnitedHealthcare Community Plan. Family planning services are also available from any Planned Parenthood (1-800-230-7526) office statewide.

Family planning services help you protect yourself from having an unwanted pregnancy and/or contracting a sexually transmitted disease. Both men and women of reproductive age are eligible to receive family planning services.

Family planning services do not require a referral, may be supplied by non-contracted providers, and are offered at no cost to you.

Knowing all your options for birth control can help you choose the right method for you. Long-acting options are a good choice for many women, and there is no charge or cost. These include:

- Intrauterine device (IUD) — A small, T-shaped plastic and or copper device that your doctor places in your uterus, or
- Birth control implant — A small rod the size of a matchstick that your doctor places under the skin on your arm.

Benefits of Long-Acting birth control options include:

- They are 99 percent effective.
- They work better than the pill and barrier methods.
- They last three to ten years, depending on which type you choose.
- They are convenient. There are no prescriptions to refill or pills to remember to take.
- They are reversible. When you want to get pregnant you can have them removed.

In addition to the IUD and birth control implant, covered family planning services also include the following:

- 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.

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- Natural family planning.
- Pregnancy screening.
- Radiological procedures, including ultrasound studies related to family planning.
- Screening, testing, and treatment for Sexually Transmitted Infections (STIs).
- Spermicidal jelly, cream, or foam: Vaginal medication.
- Treatment of complications resulting from contraceptive use, including emergency treatment.
- Tubal ligation: Surgical procedure for women 21 and older.
- Vasectomy: Surgical procedure for men 21 and older.

The following are not covered for the purpose of family planning services:

- Infertility services including diagnostic testing, treatment services or reversal of surgical infertility.
- Pregnancy termination counseling.
- Pregnancy terminations (see section below for situations when medically necessary pregnancy terminations are covered).
- Hysterectomies.

If you lose eligibility for AHCCCS services, UnitedHealthcare Community Plan can help you find low-cost or no-cost family planning services, call your Case Manager or call the Arizona Department of Health Services Hotline at 1-800-833-4642. Planned Parenthood provides low-cost family planning services. You can call 1-800-230-7526 for the office closest to you. Arizona Family Health Partnership can also help you find low- or no-cost family planning services. Contact Arizona Family Health Partnership at 602-258-5777 or 1-888-272-5652 if you live outside of the Phoenix area.

If you need treatment for a sexually transmitted infection (STI), contact your doctor, an STI Specialist, or the Arizona Department of Health Services at 602-542-1025. Services provided by the Arizona Department of Health Services are also available to you if you lose AHCCCS coverage. We can also help you find low-cost or no-cost primary care services if you lose eligibility. If you need help finding these services, call Member Services.

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 all of our members to a dental home. This is like your Primary Care Physician, but for dental care.

Routine dental services are covered for members under the age of 21. Some of these services include:

- Dental exams, two per year.
- Application of topical fluoride.
- Fillings for cavities.
- Dental sealants.
- Dental cleanings.
- Emergency dental services
- X-rays to screen for dental problems.

Members 21 years of age and older have a \$1000 benefit for routine dental services, including dentures, and a \$1000 benefit for emergency dental services for each 12 month period beginning October 1st through September 30th.

You would see your dental home for your dental care. We send you the name and address of the dentist you are 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 myuhc.com/CommunityPlan or <https://www.uhccommunityplan.com/az/medicaid/long-term-care.html> 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 provider appointments:

Urgent Care:	Appointments are to be scheduled as soon as the member's health condition require, but no later than 3 business days from the request.
Routine Care:	Within 45 calendar days of the request.

Getting your prescriptions (medications)

Getting prescription medications is an important part of your health care. If your doctor prescribes a medicine that's listed on your plan's preferred drug list (PDL), it's covered, less any possible copay (this list is also known as a formulary.) If your drug is not listed on the PDL, your care provider may request an alternative drug for you that is listed on the PDL. UnitedHealthcare Community Plan covers medicines on this list and may pay for other medicines with prior approval. See below for information on prior approval. You can get your prescriptions filled at any pharmacy in our network. Many are available 24 hours a day, 7 days a week. For a list of pharmacies, use your provider directory or go to myuhc.com/CommunityPlan.

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.

Prior approval

Prior approval (authorization) of prescription drugs

If your prescription drug is not listed on the PDL, or is listed but requires prior approval, your care provider can request prior approval for you, so you can still get that drug. We will approve or deny the request within 24 hours. If a request is approved, you and your primary care provider (PCP) will be informed of the decision in writing including the drug approval length of time. If a request is denied, you and your PCP will be informed of the decision in writing. The written decision notice will tell you how and when to appeal this decision and how to file a complaint or grievance with UnitedHealthcare Community Plan.

90 day supply benefit

Members can fill a 90 day supply of select maintenance medication at the retail pharmacy. Maintenance medications are typically those medications you take on a regular basis for a chronic or long term condition.

With a 90 day supply, you won't need to get a refill every month. To find out more details, talk to your doctor or pharmacist. For a complete list of medications included in this benefit call Member Services.

You have the ability to get maintenance medications by mail order. If you qualify, you can get a 90-day supply of your maintenance medications by mail and you won't need to get a refill every month. Call Member Services for more information and to request a Mail Order Enrollment form.

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.

There may be situations where the plan feels it's necessary to limit a member to a single pharmacy or prescribing physician due to inappropriate prescription use. You will be provided with a written letter explaining the reasons for this limitation before it happens. This letter will also include your right to appeal. The situations that can result in limiting a member to a single pharmacy or prescribing physician are listed below:

Over-Utilization	Member utilized the following in a 3 month time period: <ul style="list-style-type: none">• 4 or more prescribers; and• 4 or more abuse potential drugs (e.g. opioids, muscle relaxers, tranquilizers); and• 4 or more pharmacies. Or Member has received 12 or more prescriptions of the medications of concern (drugs with abuse potential) in the past three months.
Fraud	Member has presented a forged or altered prescription to the pharmacy.

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 <https://www.uhccommunityplan.com/az/medicaid/long-term-care.html>.

You have the right to accept or refuse behavioral health services offered to you. If you want to get the behavioral health services offered, you or your legal guardian must sign a “Consent to Treatment” form. This form gives you or your legal guardian’s permission for you to get behavioral health services. When you sign a “Consent to Treatment” form, you’re also giving AHCCCS permission to access your records.

To give you certain services, your provider needs to get your permission. Your provider may ask you to sign a form or to give verbal permission to get a specific service. Your provider will give you information about the service so you can decide if you want that service or not.

This is called informed consent. Informed consent means advising a patient of a proposed treatment, surgical procedure, psychotropic drug or diagnostic procedure; alternatives to the treatment surgical procedure, psychotropic drug or diagnostic procedure; associated risks and possible complications; and getting documented authorization, or approval for the proposed treatment, surgical procedure, psychotropic drug or diagnostic procedure from the patient or the patient’s representative.

Members are assessed for their health care needs and social determinants of health by their PCP, behavioral health provider, or care manager. A member’s assessment may indicate a housing need. Supported housing services are designed to assist individuals or families to obtain and maintain housing in various settings depending on member need, with emphasis on independent community settings including the person’s own home or apartments and homes owned or leased by a subcontracted provider.

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

- Behavioral health medicines, monitoring, and adjustment.
- Behavioral health therapeutic home care services.
- Behavior management (personal care, family support/home care training, peer support).
- Doctor services.
- Emergency and non-emergency transportation.
- Emergency behavioral health care.

Questions? Visit [UHCCommunityPlan.com](https://www.uhccommunityplan.com), 49
or call Member Services at **1-800-348-4058**, TTY 711.

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- Individual, group and family therapy and counseling.
- Inpatient hospital services, detoxification, and behavioral health residential services.
- Inpatient psychiatric facility services.
- Laboratory and radiology services.
- Opioid agonist treatment.
- Partial care (supervised day program, therapeutic day program, specialized outpatient substance use program and medical day program).
- Psychosocial rehabilitation (living skills training; health promotion; supportive employment services).
- Psychotropic medications, adjustments and monitoring.
- Rehabilitation services.
- Respite care – with limits.
- Screening, evaluation, and diagnosis.
- Substance use (drug, opioid, and alcohol) counseling, medication assisted treatment.
- Support services.
- Treatment planning.

You may self-refer to a behavioral health provider, or be referred by providers, schools, State agencies, or other parties. You may see a behavioral health counselor, addiction specialist, psychologist, or psychiatrist without a referral from your PCP. To access behavioral health services call your case manager, the behavioral health number on your ID card, use your provider directory or visit our website at <https://www.uhccommunityplan.com/az/medicaid/long-term-care.html>.

What if I am experiencing a Behavioral Health Crisis?

If you are experiencing a behavioral health crisis it is important for you to get help right away. Please call the crisis phone number for your area located on page 11 of this handbook.

Substance Use Disorder Helpline 855-780-5955 — is a free, anonymous resource for pregnant women and women in their postpartum period (up to one year) who are seeking help for themselves or a loved one who need help with Substance Use Disorder. For more information see page 42 of this handbook or call the Substance Use Disorder Helpline directly.

All members are covered for behavioral health services in a crisis or emergency situation.

Behavioral health appointments are to be scheduled as soon as the member's health condition requires but no later than the following:

Urgent behavioral health appointments — Are within 24 hours from the identification of need.

Routine care appointments — The initial assessment to be completed within 7 calendar days of referral or request. The first behavioral health service following the initial assessment is as soon as the member's health condition requires but for members age 18 or older, no later than 23 calendar days after the initial assessment and for members under the age of 18 years old, no later than 21 days after the initial assessment. All other behavioral health services to be completed as soon as the member's health condition requires, no later than 45 calendar days.

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

For referrals for psychotropic medications

For Psychotropic Medications the need will be immediately assessed. An appointment will be scheduled no later than 30 calendar days from the identification of need. If you are running out of medication or if you have a decline in your behavioral health condition prior to starting medication you can be seen sooner.

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, a SMI eligibility evaluation can be obtained at any qualifying AHCCCS behavioral health intake provider. Please call Member Services at **1-800-293-3740**, TTY **711** for more information on how to be connected with a qualified AHCCCS behavioral health provider or talk with your Case Manager. A member must be 17 and a half years of age or older to be assessed for SMI eligibility. A member or the member's guardian must provide consent to be assessed. In order to be eligible for SMI services, the member must have a qualifying diagnosis and functional impairment as a result of the qualifying diagnosis.

Members requesting an SMI determination must be assessed by a qualified provider within 7 days of their request. An SMI determination will be issued by the determining entity Crisis Response Network (CRN) within 3 business days of the assessment. CRN is the designated entity responsible for managing all SMI eligibility determination appeals. All other behavioral health related appeals are processed by UnitedHealthcare Community Plan. CRN will provide written notice of their decision with appeal instructions if the member disagrees with their decision. For more information about CRN timelines visit: <https://www.crisisnetwork.org/smi/community/#what-is-smi-determination> or you can call CRN at 1-855-832-2866.

Questions? Visit [UHCCommunityPlan.com](https://www.uhc.com), 51
or call Member Services at **1-800-348-4058**, TTY **711**.

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If an LTC member is determined SMI the member's health plan will change from UnitedHealthcare Community Plan to a Regional Behavioral Health Authority (RBHA).

Members who are already determined to be SMI may be eligible to receive:

- Special Assistance.
 - Special Assistance is support provided to an individual who is unable due to a specific condition to communicate his/her preferences and/or to participate effectively in the development of his/her service plan, discharge plan, the appeal process and/or grievance/investigation process.
 - If you need Special Assistance please speak with your behavioral health provider, Case Manager, or contact AHCCCS Office of Human Rights at 1-800-421-2124.
- Non-Title XIX/XXI 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.
 - Mental health services (previously known as Traditional Healing Treatment) 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.

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.

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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, and
 - 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.

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5. Best practices:

- a. Behavioral health services are provided by competent individuals who are trained and supervised,
- b. Behavioral health services are delivered in accordance with guidelines that incorporate evidence-based “best practices,”
- c. Behavioral health service plans identify and appropriately address behavioral symptoms that are 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

54 **Questions?** Visit UHCCCommunityPlan.com,
or call Member Services at **1-800-348-4058**, TTY **711**.

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 meet your unique needs. 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, Suite 100
Phoenix, AZ 85013
602-914-1520
855-598-1871

Children's Rehabilitative Services

1200 North Beaver
Flagstaff, AZ 86001
928-773-2054
800-232-1018

Children's Clinics

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

Children's Rehabilitative Services

2851 South Avenue B
Building 25 #2504
Yuma, AZ 85364
928-336-2777
800-837-7309

Questions? Visit UHCCommunityPlan.com, 57
or call Member Services at 1-800-348-4058, TTY 711.

Children's Rehabilitative Services (CRS)

What is CRS?

Children's Rehabilitative Services (CRS) is a designation given to certain AHCCCS and DDD members who have qualifying health conditions. Members with a CRS designation can get the same AHCCCS covered services as non-CRS AHCCCS members and are able to get care in the community, or in clinics called multispecialty interdisciplinary clinics (MSIC). MSICs bring many specialty providers together in one location. Your health plan will assist a member with a CRS designation with closer care coordination and monitoring to make sure special health care needs are met.

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

Who is eligible for a CRS designation?

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

- Under age 21; and
- Have a qualifying CRS medical condition.

The medical condition must:

- Require active treatment; and
- Be found by AHCCCS DMS to meet criteria as specified in A.A.C. R9-22-1303.

Anyone can fill out a CRS application including a family member, doctor, or health plan representative. The CRS Unit can also help with completing the application. You can contact the CRS Unit at: 602-417-4545 or 1-855-333-7828.

For more information visit:

<https://www.azahcccs.gov/PlansProviders/CurrentProviders/CRSreferrals.html>

To apply for a CRS designation mail or fax:

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

UnitedHealthcare Community Plan will provide medically necessary care for physical and behavioral health services and care for the CRS condition.

Member Council

UnitedHealthcare Community Plan Long Term Care Advisory Councils provide a forum for Health Plan Members, local Long Term Care providers and local community agencies to give recommendations about Long Term Care services. At meetings we discuss new and ongoing AHCCCS programs. It is a great opportunity for Members to provide input about current processes and future changes to the ALTCS program. We talk about how to improve care for our members. Any Health Plan member can go to meetings. We would like you to be a part of our Long Term Care Member Advisory Council. For more information contact your Case Manager.

Preauthorization process

How will I know if a service has been approved (authorization) or denied?

UnitedHealthcare Community Plan reviews the service request from you, your PCP, or your specialist. Your doctor will tell you if the service is approved. If the service has been denied, UnitedHealthcare Community Plan will send you a letter, called a Notice of Adverse Benefit Determination. You have a right to know the criteria that are used to make decisions. Normal authorization decisions will be made within 14 calendar days from the date the request is received.

Extensions of up to 14 calendar days can be received if it is in your best interest. For example, we may be waiting to receive your medical records from your doctor. Instead of making a decision without those records, we may ask you if it's okay to get more time to receive the records. That way, the decision can be made with the best information. We will send you a letter asking for the extension.

Expedited (Rush) decisions in urgent, life-threatening situations should be made in no later than 72 hours following the receipt of the authorization request unless an extension is in effect. For more information, call Member Services on Notice of Adverse Benefit Determination letters and actions you can take.

Call Member Services for more information about filing an appeal

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

Prior approval for an out-of-network provider

UnitedHealthcare Community Plan is a managed care plan. You should use the providers in our contracted network. However, there may be times when you need care from a provider that's not in our network. An out-of-network provider can request preauthorization to treat you. If the request is approved, you may see the out-of-network provider.

Prior Authorization medication

Some medications may require prior-authorization. Prior-authorization decisions for medications will be made within 24 hours from the receipt of the request. If additional information is needed, UnitedHealthcare will send a request to your provider and issue a final decision no later than 7 working days from the date of the request. Please see UnitedHealthcare's drug list at UHCommunityPlan.com.

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.

Copayments

ALTCS members do not have to pay any Medicaid copayments to providers.

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](https://www.uhccommunityplan.com).

AHCCCS covers drugs which are medically necessary, cost-effective, and allowed by federal and state law.

Medicaid does not cover medications covered by Medicare Part D and does not pay for Medicare copayments, coinsurance, or the deductible for Medicare Part D medications. AHCCCS covers medications that are excluded from coverage under Medicare Part D when medically necessary. An excluded drug is a medication that is not eligible for coverage under Medicare Part D. AHCCCS may cover some medications that are Over-the-Counter, refer to the UnitedHealthcare Over-the Counter Drug List for a list of products available on our website at [UHCCommunityPlan.com](https://www.uhccommunityplan.com) or call Member Services to request a printed copy.

Member grievances (complaints) and appeals not related to a Serious Mental Illness (SMI) reason

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

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

UnitedHealthcare Community Plan will let you know when we receive your grievance and we will look into the problem and decide what to do. If your provider has your written permission they can file a grievance on your behalf.

Most grievances are resolved within 10 working days but not more than 90 calendar 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.

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: Member Grievance and Appeals
1 East Washington Street, 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 no later than 12 months from the date of the alleged violation or condition requiring investigation occurred. 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.

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AHCCCS will send you a letter within 5 working 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.

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

An adverse benefit determination is when UnitedHealthcare Community Plan does any of the following:

- Denies or limits a requested service based on type or level of service, meeting medical necessity, appropriateness, setting, effectiveness;
- Reduces, suspends, or terminates a previously authorized service;
- Denies partial or full payment of a service;
- Fails to make an authorization decision or to provide services in a timely manner;
- Fails to resolve a grievance or appeal in a timely manner;
- Denies a rural member's request for services outside the network when the health plan is the only one in the area.

If UnitedHealthcare Community Plan makes an adverse benefit determination, you will receive a letter called a Notice of Adverse Benefit Determination. This letter will tell you:

- What your doctor asked for.
- What action was taken and why.
- Your right to file an appeal, ask for a State Fair Hearing, or ask for an expedited resolution.
- If you were receiving benefits, your right to have your benefits continue during your appeal and how to do it.

If you do not understand your Notice of Adverse Benefit Determination, call Member Services. You have a right to know the criteria that are used to make decisions. You can also file a grievance if you do not feel the letter was clear enough for you. If you are still not happy about the notice, you may contact AHCCCS by email MedicalManagement@azahcccs.gov.

Member appeals

Appeals not related to a Serious Mental Illness (SMI)

If you do not agree with a decision made by UnitedHealthcare Community Plan you can ask us to review the request again. This request for a review is called an appeal. The appeal can be written or verbal. Unless you need an expedited appeal, your verbal appeal must be followed up in writing. If you want to file a verbal appeal, call Member Services, **1-800-293-3740**, TTY 711.

UnitedHealthcare Community Plan will provide assistance to you in completing forms and taking other procedural steps related to filing an appeal. Your provider or representative can also file an appeal on your behalf with your written permission. You or your representative must file an appeal within 60 days from the date of the notice letter. You or your provider can't be retaliated against for filing an appeal. This means UnitedHealthcare Community Plan will not be upset at you or your provider or attempt to get back at either of you for filing an appeal.

Send your written appeal to:

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

When UnitedHealthcare Community Plan gets your appeal, we will send you a letter telling you that we received your appeal. If you want to continue your services during the appeal process, you must tell us no later than 10 calendar days from the date of the Notice of Adverse Benefit Determination letter. If AHCCCS agrees with UnitedHealthcare Community Plan's decision, you may have to pay for these services.

UnitedHealthcare Community Plan will make every effort to investigate your appeal within 30 calendar days. If your doctor or UnitedHealthcare Community Plan feels that your appeal should be reviewed more quickly due to the seriousness of your condition, you will receive a decision about your appeal within 72 hours. You may ask for a quicker decision too. This is known as an expedited appeal. If your appeal does not need to be reviewed quickly, we will try to call you and within 2 calendar days and will send you a letter letting you know that your appeal will be reviewed within 30 calendar days. The letter will explain how to file a grievance if you don't agree with our decision to take more time.

The appeal process may take up to 14 calendar days longer if you ask for more time to submit information or UnitedHealthcare Community Plan needs to get additional information from other sources. If we need additional information, we will call and send you a letter within 2 calendar days. The letter will explain how to file a grievance if you don't agree with our decision to take more time.

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When UnitedHealthcare Community Plan decides your appeal, we will mail a Notice of Appeal Resolution letter to you. This letter will tell you the reason for the decision. If UnitedHealthcare Community Plan decides that you should not receive the denied service, the letter will also tell you how to ask for a State Fair Hearing and, if you were receiving benefits, your right to have your benefits continue during your State Fair Hearing and how to do it.

You or your provider can't be retaliated against for filing an expedited appeal. This means UnitedHealthcare Community Plan will not be upset at you or your provider or attempt to get back at either of you for filing an expedited appeal.

State Fair Hearing

If you do not agree with UnitedHealthcare Community Plan's decision on your appeal, you can request a State Fair Hearing. Your request for a State Fair Hearing must be in writing and received within 120 calendar days from the date you receive the appeal resolution letter.

AHCCCS will send you information on how your State Fair Hearing will be handled. The AHCCCS Administration will decide if UnitedHealthcare Community Plan's decision was correct. If AHCCCS decides that UnitedHealthcare Community Plan's decision was correct, you may have to pay for services you received during the State Fair Hearing. If AHCCCS decides that UnitedHealthcare Community Plan's decision was not correct, UnitedHealthcare Community Plan will authorize and pay for services promptly.

Appeals for SMI determination and for other SMI reasons

A serious mental illness (SMI) is a mental disorder in persons 17 and a half years of age or older that's severe and persistent. Crisis Response Network (CRN), a provider that has a contract with AHCCCS, 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 XIX/XXI 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.

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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.
- The right to get member survey summaries.
- The right to be treated fairly regardless of your race, ethnicity, national origin, religion, gender, age, behavioral health condition (intellectual) or physical disability, sexual preference, genetic information, or ability to pay.
- 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 45 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.

Immunizations (shots)

Immunizations (shots) can keep you and your child from getting sick in the future. Talk with your child's PCP about the immunizations that are needed and when they are needed. The best place for children to get their immunizations is at their PCP's office. You should use an immunization schedule and have the schedule updated when you visit your child's doctor.

Here are the essentials to know about each of these vaccines.

DTaP protects against diphtheria, tetanus, and pertussis (whooping cough). It requires five doses during infancy and childhood. DTaP boosters are then given during adolescence and adulthood.

HepA protects against hepatitis A. This is given as two doses between 1 and 2 years of age.

HepB protects against hepatitis B (infection of the liver). HepB is given in three shots. The first shot is given at the time of birth.

Hib protects against Haemophilus influenzae type b. This infection used to be a leading cause of bacterial meningitis. Hib vaccination is given in three or four doses.

HPV protects against cancers caused by Human papillomavirus. Children 11 or 12 years of age should get two shots of HPV, six to 12 months apart.

Influenza (flu) protects against the flu. This is a seasonal vaccine that is given yearly. Flu shots can be given to your child each year, starting at age 6 months. Flu season can run from September through May.

IPV protects against polio and is given in four doses.

Meningococcal protects against the bacteria that causes meningococcal disease. Children should get this vaccine at 11 or 12 years of age.

MMR protects against measles, mumps, and rubella (German measles). MMR is given in two doses. The first dose is recommended for infants between 12 and 15 months. The second dose is usually given between ages 4 and 6 years. However, it can be given as soon as 28 days after the first dose.

PCV protects against pneumococcal disease, which includes pneumonia. PCV is given in a series of four doses.

RV protects against rotavirus, a major cause of diarrhea. RV is given in two or three doses, depending on the vaccine used.

Tdap protects your child from diphtheria, tetanus and whooping cough. Children should get this vaccine at 11 or 12 years of age.

Varicella protects against chickenpox. Varicella is recommended for all healthy children. It's given in two doses.

Adult care

Getting care early may help your doctor find and treat health problems and keep you healthy. Follow the schedule below for your wellness care. Your PCP will also give you tips to stay healthy, like eating right and exercising regularly.

Adult care schedule

Type of Service	21 – 64 Years Old	65 Years Old and Over
Blood pressure check	Every year (additional tests based on your health history)	Every year (additional tests based on your health history)
Breast exam	Every year	Every year
Cholesterol check	Once (additional tests based on history)	Based on history
Colorectal cancer	Every year from age 50	Every year
Flu vaccine	Every year	Every year

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Type of Service	21 – 64 Years Old	65 Years Old and Over
Health education	Every doctor visit	Every doctor visit
HIV screening	Ask your doctor if you are at risk	Ask your doctor if you are at risk
Immunizations (shots)	Ask your doctor if you are at risk	Ask your doctor if you are at risk
Mammogram	Every year for age 40 and over or based on medical need	Every year
Pap smear	Annually for sexually active women	See your PCP or GYN
Physical exam (unclothed)	Every year	Every year
Pneumonia vaccine		Once on or after age 65
Prostate screening	Every year after age 50 (additional tests based on your health history)	Every year
Sexually Transmitted Disease screening	At least once during pregnancy (additional tests based on your health history)	Ask your doctor if you are at risk
Tdap (tetanus/diphtheria/acellular pertussis)	Every 10 years	Every 10 years
Testicular exam	Every 2 years from age 18 – 39	Not required
Tuberculosis screening	Once (additional tests based on your health history)	Ask your doctor if you are at risk

These are general guidelines. Your PCP may want you to get these services more or less often.

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: <https://www.azag.gov/seniors/life-care-planning>
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.

Long Term Care Member Handbook

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 illegal. 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.

Member and family member support information and community resources and the Office of Individual and Family Affairs (OIFA) Member advocacy/liasons/coordination

UnitedHealthcare Community Plan supports our members by having member liaisons and Office of Individual and Family Affairs to support members' needs where unique community resources are available. These liaisons can be reached by emailing advocate.oifa@uhc.com or calling Member Services at 1-800-348-4058. Examples of these supports are listed below:

Adult behavioral member liaison — A member liaison with adult behavioral health experience works with adult members with special health care needs, their families, member liaisons and others within the community. The adult behavioral member liaison will assist members navigate between their physical, behavioral health and social needs. They will make certain that request, complaints, and concerns are addressed and followed up to completion for the member.

Child and family behavioral member liaison — A member liaison with child behavioral health experience working with children with special health care needs, their families, member liaisons and other within the community. The child and family behavioral member liaison will assist members/parent(s)/guardian(s) to navigate between their child’s physical, behavioral health and social needs. They will make certain that request, complaints, and concerns are addressed and followed up to completion for the member/parent(s)/guardian(s).

Court coordinator — A single point of contact for information specific to the court’s disposition for eligible members (e.g. Drug Court, Mental Health Court, Criminal Proceedings), coordination of court ordered evaluation and treatment, and who assist to assure court related follow-up.

CRS liaison — Your single point of contact for members with a CRS designation. This person works with the members assigned Multi-Specialty Interdisciplinary Clinic (MSIC) to help members/parent(s)/guardian(s) navigate between their child’s physical, specialty care, behavioral health and social needs. They will make certain that request, complaints, and concerns are addressed and followed up to completion for the member/parent(s)/guardian(s). For more information email CRS_SpecialNeeds@UHC.com.

Justice system liaison — Your single point of contact for communication with the justice system; This person works with the Arizona Department of Corrections (ADOC), County Jails, Sherriff’s Office, Correctional Health Services, Arizona Department of Juvenile Corrections (ADJC), Arizona Office of the Courts (AOC) and Probation Departments.

Tribal Coordinator — Coordinates care and service for American Indian members with tribal nations and tribal providers, promoting services and programs to improve the health of American Indian members. The Tribal Coordinator assist to assure American Indian members request, complaints, and concerns are addressed and followed up to completion.

Veterans Advocate — The Veterans Advocate is experienced in working with Veterans and family members of veterans, advocates and providers. The Advocate provides education and support to our veterans to help them through the health system to assure their medical needs are met. Additionally, they provide assistance to members needs such as employment and housing. Their goal is to provide one-on-one support to our Veteran members. For more information email the Veteran Advocate at milvet_advocate@uhc.com.

Community resources

AHCCCS Office of Individual and Family Affairs

The Office of Individual and Family Affairs (OIFA) promotes recovery, resiliency, and wellness for individuals with mental health and substance use challenges.

<https://www.azahcccs.gov/AHCCCS/HealthcareAdvocacy/OIFA.html>

OIFA Peer-Run and Family-Run Organizations

Peer-run organizations are service providers owned, operated and administrated by persons with lived experiences of mental health and/ or substance use disorders. These organizations are based in the community and provide support services.

Here are some of the things you can find at a peer-run organization:

- 1-on-1 peer support.
- Daily support groups.
- Social outings.
- Meals.
- Employment programs.
- Learning opportunities.
- Health and exercise programs.
- Creative arts.
- Resources.
- Advocacy.
- Volunteer opportunities.
- Youth and young-adult programs.
- Meeting new people.
- Personal development, and empowerment.
- Extended hours and/or weekends.

<https://www.azahcccs.gov/AHCCCS/Downloads/PeerRunOrganizationsFlyer.pdf>

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.

Phone: 2-1-1 within Arizona or 1-800-367-8939 TDD

<https://211arizona.org/>

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 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

TTY/TDD: 602-279-7270

Arizona Department of Health Services (ADHS) Breastfeeding Program 24/7 Hotline

Get answers to your breastfeeding questions 24 hours a day by calling the 24-Hour Breastfeeding Hotline at 1-800-833-4642 or by visiting www.gobreastmilk.org.

Arizona Governor’s Council on Spinal and Head Injuries

<http://www.azheadspine.org>

or by phone: 1-602-774-9147

AzEIP

The Arizona Early Intervention Program (AzEIP) is a statewide system of supports and services for families and children birth to age 3, with disabilities or developmental delays. For more information about AzEIP, call 602-532-9960, call toll-free at 1-888-439-5609, or visit the website at des.az.gov/services/disabilities/developmental-infant. If AzEIP services are provided by UnitedHealthcare Community Plan, call 1-800-293-3740, or visit the website UHCCommunityPlan.com.

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.

AZ Suicide Prevention Coalition

To change those conditions that result in suicidal acts in Arizona through awareness, intervention, and action.

<http://www.azspc.org>

Long Term Care Member Handbook

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)

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 8:30 a.m. – 8:00 p.m. Eastern Standard Time, Monday – Friday.

Or write:

American Diabetes Association

ATTN: Center for Information

2451 Crystal Drive, Suite 900

Arlington, VA 22202

Dump the Drugs AZ

<https://azdhs.gov/gis/dump-the-drugs-az/>

602-542-1025

Fussy Baby/Birth to Five Helpline

Provides support for parents who are concerned about their baby's temperament or behavior.

Helpline: 1-877-705-5437, 8:00 a.m. – 8:00 p.m., Monday – Friday

www.raisingarizonakids.com/2019/01/birth-to-five-helpline-soothe-fussy-babies

Head Start

Head Start and Early Head Start are programs that provide health, educational, nutritional, social, and other services to low-income children and families. Head Start programs create learning environments that support a child's growth in language, literacy, mathematics, science, social and emotional functioning, creative arts, and physical skills. To learn more about the Head Start program or to find a program in your area, call 1-866-763-6481 or visit the Head Start websites at <http://eclkc.ohs.acf.hhs.gov/hslc/HeadStartoffices> or <https://www.azheadstart.org/>.

Health-e-Arizona Plus

www.healtharizonaplus.gov

Allows AHCCCS members to view information about their health care and plan enrollment for:

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

Help to stop smoking

Would you like to make a plan to quit smoking? Visit myuhc.com/CommunityPlan for more information on your smoking cessation benefits. You can also get support and information from Quit for Life® at quitnow.net or call **Quit For Life®**. Get free help quitting smoking (toll-free). **1-866-784-8454**, TTY 711

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

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Home visiting programs – Strong Families AZ

Home visiting programs are available for pregnant women and families with children birth to age 5. There is no cost and a trained home visitor comes to the home to help families with education on topics such as: parenting, breastfeeding, employment and child care solutions, child abuse/child neglect prevention, child development, health and wellness, and school readiness.

If you live in Maricopa County and would like more information on Home Visiting programs, contact Parents Partners Plus at 602-633-0732 or fill out a referral form here: <https://www.parentpartnersplus.com/contact-us>. Outside Maricopa County, go to <https://strongfamiliesaz.com/programs/> to find information on Home Visiting programs available in your area.

Mentally Ill Kids in Distress (MIKID)

MIKID improves the behavioral health and wellness of children and youth through a family-centered approach.

<http://www.mikid.org>

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.namiarizona.org/>

602-244-8166

National Suicide Prevention Lifeline

<https://suicidepreventionlifeline.org/>

1-800-273-8255

Teen Lifeline:

<https://teenlifeline.org/>

602-248-8336 (TEEN)

800-248-8336 (TEEN)

Opioid assistance and referral

Local medical experts offer patients, providers, and family members opioid information, resources and referral 24/7. Translation services available.

1-888-688-4222

<https://cosancadd.org/opioid-assistance>

Poison Control

1-800-222-1212

www.poison.org

Postpartum Support International (AZ Chapter Resource List)

Warmline: 1-888-434-6667

www.postpartum.net

Power Me A2Z

Free vitamins for Arizona women ages 18 – 45 from the Arizona Department of Health Services.

www.powermea2z.org

Sliding fee clinics

If a member loses AHCCCS eligibility there are clinics around the state that offer low to no cost services. Contact the Arizona Department of Health for more information.

602-542-1219

<https://azdhs.gov/prevention/health-systems-development/sliding-fee-schedule/index.php>

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; as well as infants and children up to five years of age 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 the 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

Toll-Free: 1-888-783-7500

Fax: 602-230-9132

24 hour Senior Help Line for urgent matters: 602-264-4357

Toll-Free: 1-888-783-7500

For hard of hearing – Text 520-775-1899

Coconino, Yavapai, Apache, and Navajo Counties

<http://nacog.org>

Northern Arizona Council of Governments
(NACOG)

AAA Office:

323 N. San Francisco Street
Flagstaff, AZ 86001

Phone: 928-213-5215

Toll-Free: 877-521-3500

Fax: 928-774-3850

Central Office:

119 East Aspen Avenue
Flagstaff, AZ 86001

Phone: 928-774-1895

Toll-Free: 1-877-521-3500

Fax: 928-773-1135

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 West McCartney Road

Casa Grande, AZ 85194-7432

Phone: 520-836-2758

Toll-Free: 1-800-293-9393

Pima County

<http://www.pcoa.org/>

Pima Council on Aging

8467 East Broadway Boulevard

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
Phone: 602-256-2245
Toll-Free: 1-800 280-2245

Northern Arizona – all counties:

New Horizons Disability Empowerment Center
9400 East Valley Road
Prescott Valley, AZ 86314
Voice/TTY: 928-772-1266
Website: www.newhorizonsilc.org

Coconino, Navajo, and Apache Counties:

ASSIST! to Independence
P.O. Box 4133
Tuba City, AZ 86045
Phone: 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: www.azdisabilitylaw.org

Behavioral health advocacy

National Lifeline for Suicide Prevention and Support

<https://suicidepreventionlifeline.org/>

Contact National Lifeline for Suicide Prevention and Support weekdays by calling 1-480-994-4407 for community information and resources outside Maricopa County, 1-800-273-8255 for suicide prevention, and call the Behavioral Health crisis line at 602-222-9444; TTY/TDD 602-274-3360; or toll-free at 800-631-1314; TTY/TDD 800-327-9254.

Mailing address is:

National Lifeline for Suicide Prevention and Support

5110 North 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.namiarizona.org/>

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/>

602-274-6287 or
1-800-927-2260

Special assistance for members determined to have SMI

The AHCCCS Office of Human Rights provides advocacy to individuals determined to have a Serious Mental Illness (SMI) to help them understand, protect and exercise their rights, facilitate self-advocacy through education and obtain access to behavioral health services in the publicly funded behavioral health system in Arizona. To find out more about the Office of Human Rights and the services it provides to SMI members, contact:

www.azahcccs.gov/ahcccs/healthcareadvocacy

Phoenix office:

701 East Jefferson Street
Phoenix, AZ 85034, MD 9005
Phone: 602-364-4585
Toll-Free: 1-800-421-2124

Tucson office:

400 West Congress, #118
Tucson, AZ 85701
Phone: 520-770-3100
Toll-Free: 1-877-524-6882

Flagstaff office:

2717 North Fourth Street, Suite 130
Flagstaff, AZ 86004
Phone: 928-214-8231
Toll-Free: 1-877-744-2250

ALTCS advocates and advocacy systems

Long Term Care Ombudsman

This 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
Phone: 602-256-2245

Northern Arizona – all counties:

New Horizons Disability Empowerment Center
9400 East Valley Road
Prescott Valley, AZ 86314
Voice/TTY: 928-772-1266

Coconino, Navajo, and Apache Counties:

ASSIST! to Independence
P.O. Box 4133
Tuba City, AZ 86045
Phone: 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: www.azdisabilitylaw.org

92 **Questions?** Visit UHCCCommunityPlan.com,
or call Member Services at 1-800-348-4058, TTY 711.

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

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
305 South 2nd Avenue
Phoenix, AZ 85003
Phone: 602-258-3434 / 1-800-852-9075

Mohave County

Community Legal Services
2701 East Andy Devine, Suite 400
Kingman, AZ 86401
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
Fax: 928-283-5460

Native American Disability Law Center
Farmington Office
905 W. Apache Street
Farmington, NM 87401
Phone: 505-566-5880 / 1-800-862-7271

Pinal County

Southern Arizona Legal Aid
1729 North Trezell Road, Suite 101
Casa Grande, AZ 85122
Phone: 520-316-8076 / 1-877-718-8086

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White Mountain Apache Tribe

White Mountain Apache Legal Aid
a division of Southern Arizona Legal Aid
202 East Walnut Street or P.O. Box 1030
Whiteriver, AZ 85941
Phone: 928-338-4845 / 1-866-312-2291

Yavapai County

Community Legal Services
148 North Summit Avenue
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

AZ 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.

New to benefits: Find out how disability benefits programs work, and learn how to plan for changes in the future.

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	1-877-809-5092	306 E Monroe Buckeye, AZ 85326	http://www.adelantehealthcare.com
Adelante Healthcare	Maricopa	1-877-809-5092	1705 W Main St Mesa, AZ 85201	http://www.adelantehealthcare.com
Adelante Healthcare	Maricopa	1-877-809-5092	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	928-645-9675	827 Vista Ave Page, AZ 86040	https://canyonlandschc.org
Canyonlands Community Healthcare	Navajo	928-645-6612	Chilchinbeto Clinic Kayenta, AZ 86033	https://canyonlandschc.org
Canyonlands Community Healthcare (Beaver Dam)	Mohave	928-347-5971	3272 East Rio Virgin Rd Littlefield, AZ 86432	https://canyonlandschc.org
CARE Partnership	Maricopa	480-833-8987	466 S Bellview Mesa, AZ 85204 (call for appointment)	https://www.freeclinics.com
Chandler Family Dental Clinic (MIHS) Chandler	Maricopa	480-344-6109	811 S Hamilton Chandler, AZ 85225	https://www.mihs.org

Community dental resources in Arizona

Clinic/ Organization	County	Phone Number	Address	Website
Clinica Adelante/ Tidwell Care	Maricopa	1-877-809-5092	306 E Monroe Ave Buckeye, AZ 85326	http://www.adelantehealthcare.com
Coconino County Dept. of Health	Coconino	928-679-7120 877-679-7120	2625 N. King Street Flagstaff, AZ 86004	http://www.coconino.az.gov/health
Donated Dental Services AZ Dental Foundation	480-344-5777 Often a waiting list.		3193 N. Drinkwater Blvd. Scottsdale, AZ 85251	http://www.azdentalfoundation.org
Maricopa Integrated Health Systems (Avondale Family Health Center)	Maricopa	623-344-6809	950 E Van Buren St Avondale, AZ 85323	https://www.mihs.org/family-health-center/
Maricopa Integrated Health Systems (Chandler Family Health Center)	Maricopa	480-344-6109	811 South Hamilton Chandler, AZ 85225	https://www.mihs.org/family-health-center/
Maricopa Integrated Health Systems (Comprehensive Healthcare Center)	Maricopa	602-344-1015	2525 E Roosevelt St Phoenix, AZ 85008	https://www.mihs.org/family-health-center/

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	https://www.mihs.org/family-health-center/
Maricopa Integrated Health Systems (McDowell Family Health Center – Specialty HIV)	Maricopa	602-344-8717	1101 N. Central Ave. Phoenix, AZ 85004	https://www.mihs.org/family-health-center/
Maricopa Integrated Health Systems (Mesa Family Health Center)	Maricopa	480-344-6209	59 S Hibbert Mesa, AZ 85210	https://www.mihs.org/family-health-center/
Maricopa Integrated Health Systems (South Central Family Health Center)	Maricopa	602-344-6489	33 W Tamarisk Phoenix, AZ 85041	https://www.mihs.org/family-health-center/
Mesa Community College Dental Hygiene Clinic	Maricopa	480-248-8195	5855 E Still Circle Mesa, AZ 85206	https://www.mesacc.edu/programs/dental-hygiene
Mountain Park Health Center	Maricopa	602-243-7277	635 E Baseline Rd Phoenix, AZ 85042	https://mountainparkhealth.org/

Community dental resources in Arizona

Clinic/ Organization	County	Phone Number	Address	Website
Mountain Park Health Center	Maricopa	602-243-7277	6601 W Thomas Rd Phoenix, AZ 85033	https://mountainparkhealth.org/
Native American Community Health Center	Maricopa	602-279-5262	4041 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	928-522-9400	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 University Dental Hygiene Clinic	Coconino	928-523-3500	NAU 208 Pine Knoll Dr Bldg 66, Rm 215 Flagstaff, AZ 86011	http://nau.edu/CHHS/DDH/Clinic
Phoenix College Dental Hygiene Clinic	Maricopa	602-285-7323	1202 W Thomas Rd Bldg R Phoenix, AZ 85013	https://www.phoenixcollege.edu/community/community-services/dental-clinic

Community dental resources in Arizona

Clinic/ Organization	County	Phone Number	Address	Website
Phoenix Indian Medical Center	Maricopa	602-263-1592	4212 N 16th St Phoenix, AZ 85016	https://www.ihs.gov/phoenix/programs/services/dental/
Rio Salado Dental Hygiene Clinic	Maricopa	480-377-4100	2250 W 14th St Tempe, AZ 85281	http://www.riosalado.edu/locations/dh/Pages/default.aspx
Salt River Health Center	Maricopa	480-946-9066	10005 E Osborn Rd Scottsdale, AZ 85256	https://www.ihs.gov/phoenix/programs/services/dental/
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 85003	https://www.stvincentdepaul.net/
Sun Life Family Health Center	Pinal	520-381-0381	865 N Arizola Rd Casa Grande, AZ 85122	http://www.sunlife.familyhealth.org
VA Medical Center Dental Clinic (100% disabled)	Maricopa	602-277-5551 ext: 6424	650 E Indian School Rd Phoenix, AZ 85012	http://www.phoenix.va.gov/services/Dental_Service.asp

Community dental resources in Arizona

Clinic/ Organization	County	Phone Number	Address	Website
VA Medical Center Dental Clinic (100% disabled)	Yavapai	928-445-4860 ext: 6177	500 Hwy 89 North Bldg 155, 1st Floor Prescott, AZ 86313	http://www.prescott.va.gov/services/Dental_Service.asp
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

201 East Cottonwood Lane, Suite 2
Casa Grande, AZ 85122
Phone: 1-520-421-1500
Toll-Free: 1-888-507-3313
Fax: 602-253-6385

Chinle ALTCS Office

Tseyi Shopping Center, Hwy. 191
P.O. Box 1942
Chinle, AZ 86503
Phone: 1-928-674-5439
Toll-Free: 1-888-507-3313
Fax: 602-253-6385

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: 602-253-6385

Flagstaff ALTCS Office

2717 North Fourth Street, Suite 130
Flagstaff, AZ 86004
Phone: 1-928-527-4104
Toll-Free: 1-888-507-3313
Fax: 602-253-6385

Globe/Miami ALTCS Office

Cobre Valle Plaza
2250 Highway 60, Suite H
Miami, AZ 85539-9700
Phone: 1-928-425-3165
Toll-Free: 1-888-425-3165
Fax: 1-928-425-7316

Kingman ALTCS Office

519 East Beale Street, Suite 130
Kingman, AZ 86401
Phone: 1-928-753-2828
Toll-Free: 888-507-3313
Fax: 602-253-6385

Phoenix ALTCS Office

801 East Jefferson Street, MD 3900
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
Toll-Free: 1-888-507-3313
Fax: 602-253-6385

Tucson ALTCS Office

1010 North Finance Center Drive
Suite 201
Tucson, AZ 85710
Phone: 1-520-205-8600
Toll-Free: 1-800-824-2656
Fax: 602-253-6385

Yuma ALTCS Office

3850 West 16th Street, Suite A
Yuma, AZ 85364
Phone: 1-928-782-0776
Toll-Free: 1-888-507-3313
Fax: 602-253-6385

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

102 **Questions?** Visit UHCCCommunityPlan.com,
or call Member Services at **1-800-348-4058**, TTY **711**.

Managed Care definitions

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

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

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

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

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

Emergency Medical Transportation: See **Emergency Ambulance Services**.

Emergency Ambulance Services: Transportation by an ambulance for an emergency condition.

Emergency Room Care: Care you get in an emergency room.

Emergency Services: Services to treat an emergency condition.

Excluded Services: See **Excluded**.

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

- Above a limit,
- Experimental, or
- Not medically needed.

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

Habilitation Services and Devices: See **Habilitation**.

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

Long Term Care Member Handbook

Health Insurance: Coverage of costs for health care services.

Home Health Care: See **Home Health Services**.

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

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

Hospital Outpatient Care: Care in a hospital that usually does not require an overnight stay.

Hospitalization: Being admitted to or staying in a hospital.

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

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

Non-Participating Provider: See **Out of Network Provider**.

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

Participating Provider: See **In-Network Provider**.

In-Network Provider: A health care provider that has a contract with your health plan.

Physician Services: Health care services given by a licensed physician.

Plan: See **Service Plan**.

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

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

Preauthorization: See **Prior Authorization**.

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

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

Prescription Drug Coverage: Prescription drugs and medications paid for by your health plan.

Prescription Drugs: Medications ordered by a health care professional and given by a pharmacist.

Primary Care Physician: A doctor who is responsible for managing and treating the member's health.

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

- Person licensed as an allopathic or osteopathic physician, or
- Practitioner defined as a physician assistant licensed or
- Certified nurse practitioner.

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

Rehabilitation Services and Devices: See **Rehabilitation**.

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

Skilled Nursing Care: Skilled services provided in your home or in a nursing home by licensed nurses or therapists.

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

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

Maternity care service definitions

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

Free Standing Birthing Centers — Out-of-hospital, outpatient obstetrical facilities licensed by the ADHS and certified by the Commission for the Accreditation of Free Standing Birthing Centers. These facilities are staffed by registered nurses to provide assistance with labor and delivery services and are equipped to manage uncomplicated, low-risk labor and delivery. These facilities shall be affiliated with, and in close proximity to, an acute care hospital for the management of complications, should they arise.

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

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

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

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

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

Postpartum — Postpartum is defined as the period beginning the day of parturition and ends the last day of the month up to the 57th day following parturition.

Postpartum Care — Health care provided for a period of up to 57 days post-delivery. Family planning services are included, if provided by a physician or practitioner, as addressed in AMPM Policy 420.

Preconception Counseling — The provision of assistance and guidance aimed at identifying/reducing behavioral and social risks, through preventive and management interventions, in women of reproductive age who are capable of becoming pregnant, regardless of whether she is planning to conceive. This counseling focuses on the early detection and management of risk factors before pregnancy and includes efforts to influence behaviors that can affect a fetus prior to conception. The purpose of preconception counseling is to ensure that a woman is healthy prior to pregnancy.

Preconception counseling is considered included in the well-woman preventative care visit and does not include genetic testing.

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

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



Contract services are funded under contract with the State of Arizona. 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**, 8 a.m. – 5 p.m., Monday – Friday.

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**, 8 a.m. – 5 p.m., Monday – Friday.

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108 **Questions?** Visit UHCCommunityPlan.com,
or call Member Services at **1-800-348-4058**, TTY **711**.

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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, 2019.

By law, we¹ 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.

Questions? Visit UHCCommunityPlan.com, 109
or call Member Services at **1-800-348-4058**, TTY 711.

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- **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. We will follow stricter laws that apply.
 1. Alcohol and Substance Abuse
 2. Biometric Information
 3. Child or Adult Abuse or Neglect, including Sexual Assault
 4. Communicable Diseases
 5. Genetic Information
 6. HIV/AIDS
 7. Mental Health
 8. Minors' Information
 9. Prescriptions
 10. Reproductive Health
 11. Sexually Transmitted Diseases

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.

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- **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.; Care Improvement Plus South Central Insurance Company; Care Improvement Plus of Texas Insurance Company; Care Improvement Plus Wisconsin Insurance; Health Plan of Nevada, Inc.; Optimum Choice, Inc.; Oxford Health Plans (NJ), Inc.; Physicians Health Choice of Texas LLC; Preferred Care Partners, Inc.; Rocky Mountain Health Maintenance Organization, Inc.; Symphonix Health Insurance, Inc.; UnitedHealthcare Benefits of Texas, Inc.; UnitedHealthcare Community Plan of California, Inc.; UnitedHealthcare Community Plan of Ohio, Inc.; UnitedHealthcare Community Plan of Texas, L.L.C.; UnitedHealthcare Community Plan, Inc.; UnitedHealthcare Insurance Company; UnitedHealthcare Insurance Company of River Valley; UnitedHealthcare of Alabama, Inc.; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Kentucky, Ltd.; UnitedHealthcare of Louisiana, Inc.; UnitedHealthcare of the Mid-Atlantic, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; UnitedHealthcare 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. This list of health plans is completed as of the effective date of this notice. For a current list of health plans subject to this notice go to www.uhc.com/privacy/entities-fn-v2-en or call the number on your health plan ID card.

112 **Questions?** Visit UHCCommunityPlan.com, or call Member Services at 1-800-348-4058, TTY 711.

Financial Information Privacy Notice

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

Effective January 1, 2019.

We² 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.

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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: AmeriChoice Health Services, Inc.; CNIC Health Solutions, Inc.; Dental Benefit Providers, Inc.; gethealthinsurance.com Agency, Inc.; Golden Outlook, Inc.; HealthAllies, Inc.; Lifeprint East, Inc.; Lifeprint Health, Inc.; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; OneNet PPO, LLC; OptumHealth Care Solutions, Inc.; Optum Women’s and Children’s Health, LLC; OrthoNet, LLC; OrthoNet of the Mid-Atlantic, Inc.; OrthoNet West, LLC; OrthoNet of the South, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; POMCO Network, Inc.; POMCO of Florida, Ltd.; POMCO West, Inc.; POMCO, Inc.; 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; and 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. This list of health plans is completed as of the effective date of this notice. For a current list of health plans subject to this notice, go to www.uhc.com/privacy/entities-fn-v2-en or call the number on your health plan ID card.



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**

United
Healthcare
Community Plan

Questions? Visit UHCCommunityPlan.com, 115
or call Member Services at **1-800-348-4058**, TTY **711**.

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