



Welcome to the community

AHCCCS Complete Care and Developmental Disabilities (DD) Member Handbook

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**United
Healthcare
Community Plan**

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

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Important information

Member Services:

Available 8:00 a.m.–5:00 p.m., Monday–Friday, excluding state holidays.

Toll-free **1-800-348-4058**

TTY/TDD (for the hearing impaired) **711**

Urgent or emergency care:

If you need urgent care, your PCP should see you within 48 hours. Urgent Care centers are also available in our network of providers. If you need emergency care, your PCP should see you that day. For life-threatening emergencies, call 911 or go to the nearest emergency room.

Websites

UHCommunityPlan.com

This is the site for members of UnitedHealthcare Community Plan.
Visit this site if you have UnitedHealthcare Community Plan.

www.HealtheArizonaPlus.gov

This website will introduce people to the new requirements for AHCCCS Health Insurance and KidsCare eligibility, and connect to the Federal Insurance Marketplace.

Your health providers

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

My member ID: _____

Behavioral health crisis: _____

My doctor: _____

My doctor's phone number: _____

My doctor's address: _____

My dentist: _____

Pharmacy: _____

Behavioral health providers: _____

Questions? Visit UHCommunityPlan.com, 5
or call Member Services at **1-800-348-4058, TTY 711.**

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Member Services

8:00 a.m.–5:00 p.m., Monday–Friday, excluding state holidays

Member Services 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

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 **1-800-348-4058**, TTY/TDD **711**, 8:00 a.m.–5:00 p.m., Monday–Friday, excluding state holidays.

NurseLine

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

Visit our website – UHCCommunityPlan.com

It has resources and helpful information. For example:

- Information about UnitedHealthcare Community Plan
- Member Handbook and Member Newsletters
- Links to the AHCCCS website
- How to find a doctor
- How to find a pharmacy
- How to find a prescription medications
- How to file a grievance or an appeal
- Links to health information
- Member education

Visit myuhc.com for personalized information

You can:

- View and print your member ID card
- Find a provider
- Manage your prescriptions
- View your benefits
- View claims and visits
- View your member handbook
- And much more!

UnitedHealthcare® mobile app

Get information on-the-go with the UnitedHealthcare mobile app. Download the UnitedHealthcare mobile app to your Apple® or Android® smartphone or tablet and see how easy it is to find nearby doctors, view the Member Handbook, find help and support in your community, or view your ID card.

Assurance Wireless Lifeline Service

As a member, or as the guardian of a UnitedHealthcare member, you may qualify for Assurance Wireless a government Lifeline Assistance program that provides a mobile phone and service plan, at no cost. As an Assurance Wireless customer, you can easily access:

- Health-related information from UnitedHealthcare
- Benefit and program reminders via text for you and your family
- UnitedHealthcare Member Services

Already have Lifeline? You can switch from your current service provider.

Choose the Lifeline service that's right for you

Visit AssuranceWireless.com/partner/buhc to apply or learn more about Assurance Wireless Lifeline plans. Get ready to enjoy mobile health support at no cost to you.

Care Management

A Care Manager can help work with you and provide resources for your medical or behavioral health needs. They will provide information and help you manage chronic conditions like asthma, diabetes, heart failure and depression if your needs require special attention. The assigned Care Manager will show you how to find and get other services such as how to stop smoking, information about weight loss, making appointments with your doctor and remind you about special tests that you might need. Our Care Managers include experienced nurses, community health workers and behavioral health specialists who will help you. We can help you enroll for programs and show you how to use services or offer how to opt out of the program if you prefer.

If you need to reach out to your care manager or if you would like more information about the care management program, contact Member Services at **1-800-348-4058**.

AHCCCS Complete Care and DD Members with Children's Rehabilitative Services (CRS) Designation contact your assigned MSIC for more information about services related to a CRS condition.

Urgent and after-hours care

If you are sick, or have a sudden health problem, but it is not an emergency, call your PCP. Even if the office is closed, an answering service will take your call. Tell the answering service or the PCP what is wrong and listen to their instructions. They may send you to another doctor or tell you to go to an urgent care center that is contracted with UnitedHealthcare Community Plan. If you need help finding an urgent care center or you cannot contact your PCP, call Member Services at **1-800-348-4058** or go to the UnitedHealthcare Community Plan website at **UHCCommunityPlan.com** to locate the nearest urgent care center.

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.

Single statewide crisis hotline: **1-844-534-HOPE (4673)**

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**

Tohono O’Odham Nation **1-844-423-8759**

Especially for teens: Teen lifeline phone or text **602-248-TEEN (8336)** or **1-800-248-8336**

Senior Help Line: 24-hour senior help line **602-264-4357**

Questions? Visit **UHCCommunityPlan.com**, 9
or call Member Services at **1-800-348-4058**, TTY 711.

AHCCCS Complete Care and Developmental Disabilities Member Handbook

National 24-hour crisis hotlines:

Phone:

National suicide prevention lifeline **1-800-273-TALK (8255) or 988**

National substance use and disorder issues

Referral and treatment hotline **1-800-662-HELP (4357)**

Text:

Text the word **“HOME” to 741741**

Chat <https://suicidepreventionlifeline.org/chat>

Online <https://suicidepreventionlifeline.org>

Trans Lifeline:

Is a peer-support crisis hotline in which all operators are transgender **1-877-565-8860**

Online www.translifeline.org

Veteran Line/Beconnected Line:

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

Veteran’s Crisis Line **1-800-273-8255, Press 1**

Online BeconnectedAZ.org

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

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Warm Line:

The Warm Line is a confidential telephone service staffed by peers who have, themselves, dealt with behavioral health challenges. Peer support specialists offer peer support and compassion for callers who just need someone to talk with. This is available statewide at no cost. Members can call any number listed below:

Central Arizona

Solari Crisis & Human Services Network **602-347-1100**
10:00 a.m.–10:00 p.m., 7 days a week
(some hold time when at high volume)

Northern Arizona

NAZCARE **1-888-404-5530**
4:00 p.m.–10:30 p.m., Monday–Thursday
3:00 p.m.–10:30 p.m., Friday–Sunday
(recorded message asks for person’s name and number and staff will return call)

Southern Arizona

HOPE, Inc:
Pima County **520-770-9909**
All other Southern AZ Counties **844-733-9912**
8:00 a.m.–10:00 p.m., 7 days a week
(recorded message: can hold or leave a voice message requesting call back)

A Family Warm Line supports family members that deal with behavioral health challenges. The support service provides confidential no cost guidance and connects people to resources for helping deal with job loss, heightened anxiety, and much more. Anyone who feels overwhelmed due to life’s current challenges is encouraged to call.

Statewide in Arizona

Family Involvement Center (FIC) Warm Line **877-568-8468**
8:30 a.m.–5:00 p.m., Monday–Friday

Health equity, language, and cultural services

At UnitedHealthcare Community Plan, we celebrate people, ideas and experiences by creating a culture where all members are appreciated, valued, and able to contribute to their full potential. Deeply rooted disparities cannot be solved through a singular program or initiative. We see the opportunity to advance health equity in nearly every aspect of our ambition to help build a modern, high-performing health system that achieves better health outcomes.

UnitedHealthcare Community Plan has created health equity resources to help connect our members to the information they need and to promote better diversity, equity, and inclusion. Please visit the Resource section of our website at [UHCCommunityPlan.com](https://www.uhc.com/community-plan). Here you can explore the Community Resource Guide to find out about health information and community services for Behavioral Health, Housing, LGBTQ+ and more.

Clear communication is important to get the health care you need. UnitedHealthcare Community Plan provides member materials to you in a language or format that may be easier for you to understand. We also have interpreters for you to use if your doctor or service provider does not speak your language. If your doctor or service provider does not understand your cultural needs, we can help. We will work with your doctor or service provider or help you pick a new doctor or service provider.

English:

Call Member Services at **1-800-348-4058** for interpreter services, to find a doctor who understands your cultural needs, or for materials in another language or format. These services are provided at no cost to you.

Español:

Llame a Servicios para Miembros al **1-800-348-4058** para obtener servicios de interpretación, para encontrar a un doctor que entienda sus necesidades culturales o por materiales impresos en otro idioma o formato. Estos servicios son provistos gratuitamente.

Somali:

Adeegyada turjumaanka ka wac Adeegga Xubnaha lambarka 1-800-348-4058, si aad u hesho dhakhtar fahmaya baahiyahaaga dhaqaneed, ama waxyaabo ku qoran luqad ama qaab kale. Adeegyadaas kuguma joogaan adiga wax kharash ah.

Simplified Chinese:

請致電會員服務部（電話：1-800-348-4058）以獲得口譯服務、尋找了解您的文化需求的醫生、或獲得其他語言或格式的材料。上述服務均免費為您提供。

Serbian:

Pozovite Službu za usluge za članove na broj 1-800-348-4058 za usluge prevodioca, da pronađete lekara koji razume vaše kulturne potrebe ili za materijale na drugom jeziku ili u drugom formatu. Ove usluge vam se pružaju besplatno.

Traditional Chinese:

請致電會員服務部（電話：1-800-348-4058）以獲得口譯服務、尋找瞭解您的文化需求的醫生、或獲得其他語言或格式的材料。上述服務均免費為您提供。

Romanian:

Sunați departamentul Servicii destinate membrilor la numărul 1-800-348-4058 pentru servicii de interpretariat, pentru a găsi un medic care înțelege necesitățile dvs. culturale sau pentru materiale în altă limbă sau în alt format. Aceste servicii vă sunt oferite gratuit.

Vietnamese:

Gọi Dịch Vụ Hội Viên theo số 1-800-348-4058 cho dịch vụ thông dịch, để tìm các bác sĩ hiểu rõ nhu cầu văn hóa của quý vị, hoặc các tài liệu bằng ngôn ngữ hoặc dạng khác. Các dịch vụ được cung cấp miễn phí cho quý vị.

Hungarian:

Hívja a tagsági szolgáltatásokat az 1-800-348-4058-as számon tolmácsszolgáltatásokhoz, hogy egy olyan orvost találjon, aki megérti az Ön kulturális igényeit, illetve más nyelvű vagy formátumú anyagokért. Ezek a szolgáltatások az Ön számára ingyenesek.

Farsi:

برای برخورداری از خدمات ترجمه شفاهی، یافتن دکتری که نیازهای فرهنگی شما را درک کند، یا دریافت اطلاعات به زبان یا فرمت دیگر با شماره 1-800-348-4058 با قسمت خدمات اعضا تماس بگیرید. این خدمات بصورت مجانی در اختیار شما قرار می گیرد.

Swahili:

Pigia Huduma za Mwanachama katika nambari 1-800-348-4058 ili kupata huduma za mkalimani, kupata daktari anayeelewa mahitaji yako ya kitamaduni, au kwa nyenzo katika lugha au mfumo mwingine. Huduma hizi zinatolewa bila malipo yoyote kwako.

Albanian:

Telefonojuni shërbimeve për anëtarët në 1-800-348-4058 për shërbime interpretimi, për të gjetur një mjek që i kupton nevojat tuaja kulturore ose për materiale në gjuhë apo format tjetër. Këto shërbime ju sigurohen falas.

Arabic:

اتصل بقسم خدمات الأعضاء على الرقم 1-800-348-4058 لخدمات الترجمة الشفهية أو العثور على طبيب يفهم احتياجاتك الثقافية أو طلب مواد بلغة أخرى أو بتنسيق آخر. تُقدّم هذه الخدمات لك مجانًا.

If you require additional assistance to communicate, such as auxiliary aids, contact Member Services. Auxiliary Aids are services or devices that help people with impaired sensory, manual, or speaking skills to have an equal opportunity to participate in the health plan. Auxiliary Aids may be provided at no cost to you, such as obtaining an audio reading of plan materials for the visually impaired. UnitedHealthcare Community Plan offers language and interpretation services in over 240 languages.

UnitedHealthcare Community Plan complies with all applicable federal and state laws, including:

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

Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI and VII) and the Americans with Disabilities Act of 1990 (ADA) Section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975, UnitedHealthcare Community Plan prohibits discrimination in admissions, programs, services, activities or employment based on race, color, religion, sex, national origin, age, and disability. UnitedHealthcare Community Plan must make a reasonable accommodation to allow a person with a disability to take part in a program, service, or activity.

UnitedHealthcare Community Plan will provide sign language interpreters for people who are deaf and enlarged print materials.

AHCCCS Complete Care and Developmental Disabilities Member Handbook

It also means that UnitedHealthcare Community Plan will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible.

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. Members with high acuity illness or high service utilization can get assistance in navigating the provider network.

Members can also use the Provider 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 the links directly to the Provider Lookup feature.

ACC: <https://www.uhcommunityplan.com/az/medicaid/ahcccs>

DD: <https://www.uhcommunityplan.com/az/medicaid/developmentally-disabled>

If you 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. For more information about this contact your PCP or call Member Services.

Welcome to UnitedHealthcare Community Plan

Making a difference, one member at a time

UnitedHealthcare Community Plan serves many different programs in Arizona.

AHCCCS Complete Care

AHCCCS Complete Care is an integrated health insurance plan for Arizona residents who meet certain income and other requirements. It offers physical and behavioral health services together to treat all aspects of your health care needs including doctor visits, hospitalization, prescription drugs, and services specific to CRS conditions.

This plan is available in the following counties: Gila, Maricopa, Pima, and Pinal Counties.

AHCCCS Complete Care members with Children's Rehabilitative Services (CRS) designation

Some AHCCCS Complete Care members have been diagnosed with a CRS condition and are designated as CRS.

Members who are designated CRS may receive specialized care at a Multi-Specialty Interdisciplinary Clinic (MSIC) in Phoenix or Tucson. At these clinics primary and behavioral health services may also be offered.

Developmental Disabilities (DD)

Our Developmental Disabilities program addresses the specific health care needs of children and adults with conditions such as autism, cerebral palsy, epilepsy or other cognitive disabilities. This program combines physical and behavioral services with community resources to help you care for yourself or to help your family care for you.

DD is available for UnitedHealthcare members statewide.

Developmental Disabilities with Children's Rehabilitative Services (CRS) designation

Some DD members have been diagnosed with a CRS condition and are designated as CRS.

Members who are designated CRS may receive specialized care at one of four Multi-Specialty Interdisciplinary Clinics (MSICs) in Phoenix, Tucson, Flagstaff or Yuma. At these clinics primary and behavioral health services may also be offered.

KidsCare

AHCCCS offers health insurance through KidsCare for eligible children (under age 19) who are not eligible for other AHCCCS health insurance. For those who qualify, there are monthly premiums.

Long Term Care (LTC)

Long Term Care programs help people who are age 65 or older, blind, or disabled and need ongoing services at a nursing facility level of care. A Case Manager assesses your needs and arranges for the services you require to stay in your home, such as attendant care, home modifications and meal delivery.

Your Member Handbook

This Member Handbook is for members of UnitedHealthcare Community Plan who receive benefits for AHCCCS Complete Care, KidsCare, or Developmental Disabilities (DD). Our AHCCCS Complete Care and KidsCare products are available in the following counties: Gila, Maricopa, Pima, and Pinal. Our DD product is available in all Arizona counties.

Please read this handbook. It will tell you:

- Your rights and responsibilities as a member
- How to get health care services
- What services are covered and not covered
- How to use your benefits
- Where to go for help
- Information about UnitedHealthcare Community Plan

You can also view your Member Handbook on our website at [UHCCCommunityPlan.com](https://www.uhc.com) or request a printed handbook be mailed to you at no cost.

UnitedHealthcare Community Plan: managed care programs to keep you healthy

UnitedHealthcare Community Plan is a managed care plan. This means that all of the medical care and service you receive must be requested and provided by a doctor or health care provider that is in the UnitedHealthcare Community Plan network.

UnitedHealthcare Community Plan understands that current members have relationships with their doctors and health care providers. To maintain these relationships, UnitedHealthcare Community Plan may allow an AHCCCS registered non-participating doctor or health care provider to treat a member if approval is provided by UnitedHealthcare Community Plan. This is called a prior authorization. UnitedHealthcare Community Plan will work with your health care providers to make sure you receive the care you need.

DD members:

Look for this box throughout the Member Handbook. It will tell you details about your unique benefits and services.

Your 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 or your child's card is wrong.

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.

Member responsibilities

You have the responsibility to:

- Read and follow this handbook
- Treat all UnitedHealthcare Community Plan staff and health care providers with respect and dignity
- Protect your ID card and show it before you get services. Do not throw your card away.
- Know the name of your Primary Care Physician (PCP). Your PCP is your doctor that coordinates your health care needs.
- See your PCP for your health care needs
- Use the emergency room for life-threatening care only. Go to your PCP for all other care. If you have an urgent problem and your doctor can't see you right away, you could go to an urgent care center.
- Follow your doctor's instructions and agreed upon treatment plan for care that you have agreed to, and tell your doctor if their explanations are not clear
- Bring your child's immunization records with you to appointments until the child is 18 years old
- Make an appointment before you visit your PCP or any other UnitedHealthcare Community Plan health care provider
- Schedule appointments during office hours to avoid the need to use urgent care centers or emergency rooms
- If you need a ride, call 1-888-700-6822 at least three days before your appointment
- Arrive on time for appointments
- Notify your provider in advance if you need to cancel your appointment
- Please call the office at least one day in advance if you must cancel an appointment. If you cancel your appointments, be sure to cancel your transportation at 1-888-700-6822.
- Supply information that your plan, practitioners, or families need in order to provide your care
- Be honest and direct with your PCP. Give them health history on you or your child.
- Understand your health issues and participate in developing mutually agreed-upon treatment goals
- Call AHCCCS if you have changes in address, family size or questions about eligibility
- Tell your doctor, AHCCCS, and UnitedHealthcare Community Plan if you have other insurance, such as Medicare. Failure to disclose information may result in denial of claims and services.
- Give a copy of your Living Will to your PCP

DD members:

With the help of your DES/DDD Support Coordinator, your responsibilities include:

- Keep your ALTCS eligibility predetermination appointments
- Select a PCP within 10 days of notification of plan enrollment
- Coordinate all necessary covered medical services through your PCP
- Go to your well visits with your PCP to help you stay healthy. Your PCP will help prevent infections by giving immunizations.
- Notify the DES/DDD Support Coordinator of changes in your address or phone number or if your private insurance has changed
- Arrive on time for your appointments or call ahead if you can't make it
- Provide all the information to your PCP that is requested by the PCP
- Notify your DDD Support Coordinator and UnitedHealthcare Community Plan with all the information, including changes in private and public insurance, third party liability, financial assistance, or other benefits received by you
- Pursue eligibility with Children's Rehabilitative Services (CRS). CRS is a special program to help with your health care if you have certain health conditions.
- Direct any complaints or problems to DES/DDD, Health Care Services, Member Services or your UnitedHealthcare Community Plan DD Liaison as soon as possible
- Participate in Person-Centered Service Plan (PCSP) meetings at the request of UnitedHealthcare Community Plan, your Support Coordinator or other personnel

Contact your DDD Support Coordinator at any time, including in-between visits, if you have any questions. Your DDD Support Coordinator can be reached by calling 1-844-770-9500, Option 1.

Changes in information

Before you move to another county, state, or country report this change to the agency that helped you with your eligibility and to UnitedHealthcare Community Plan right away. If you move to a county that is not served by UnitedHealthcare Community Plan, you will need to change your health plan. Changes you must report include:

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

Contact the agency that helped you with eligibility to request changes

DES — 1-855-HEA-PLUS (1-855-432-7587)

KidsCare — 1-855-HEA-PLUS (1-855-432-7587)

SSI MAO — 602-417-5010

Social Security Administration — 1-800-772-1213

DD members:

Call your DDD Support Coordinator and ask to have an electronic Member Change Report submitted to correct your information. Your DDD Support Coordinator can be reached by calling 1-844-770-9500, Option 1.

What care is available outside my service area?

When you are outside your service area, for example, outside of Arizona, 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.

Changing health plans

Every year 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:

- You weren't given a choice of plan, weren't notified of your AEC period or couldn't make a choice because of a reason that you could not control
- You were not enrolled in the same health plan as other family members
- You lost eligibility for 90 days or less and were not re-enrolled with the same health plan
- A newborn or adoption subsidy child may have up to 90 days following auto-assignment to change plans. A Title XIX eligible member who is auto-assigned prior to having the full choice period of 90 days will be given 90 days from the date of the choice letter to request a plan change.

If you meet any of the reasons above, you may request a plan change from AHCCCS by calling 1-800-654-8713, or calling 602-417-4000 in Maricopa County.

You may also be able to request a change to another health plan if you:

- Have a medical continuity of care issue for a pregnancy. This means you have already been seeing a doctor outside of our network for your current pregnancy.
- Have another medical continuity of care issue

If you meet either of these reasons, you must request your plan change from your current health plan. If you are a UnitedHealthcare Community Plan member, you may contact Member Services to request this change. Member Services will fill out the required paperwork and send it to the other health plan. If your request is denied, you will receive a denial letter. If you do not agree with the decision you may file a grievance. Information on how to file a grievance will be included in the denial letter. You may call Member Services at any time to help with this process.

If you change plans for any reason, your current health plan and new health plan will work together to make sure you have no delay in services and have continued access to care in services. This includes a change to or from an AHCCCS Fee For Service health plan.

DD members:

DD members are able to change health plans during their birth month. Call DDD Member Services at any time to help with the process at 1-844-770-9500, Option 7.

Treatment planning

A Treatment Plan is a written plan of care to help identify your medical, behavioral health and social service needs. Resources will be provided to help with your care based on a completed assessment and plan of care created by your care team. The plan of care is a description of all covered health services and other supports which may include your personal goals, family support services, care coordination action items, and plans to help you in achieving an improved quality of life.

UnitedHealthcare Community Plan provides family-centered care that includes your family in the decisions that you make with your PCP, Behavioral Health Provider, MSIC, Specialists, and/or Care Manager. You may allow a family member or authorized representative to partner 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 your medical, functional, social and behavioral health needs. If you feel your voice is not being heard please contact Member Services for help at **1-800-348-4058**.

DD members:

The ALTCS Transitional Program is available for members who, at the time of medical reassessment, have improved either medically, functionally or both, where they no longer need institutional care, but who still need long-term care services and supports. ALTCS Transitional members are entitled to all ALTCS covered services except for custodial nursing facility care. UnitedHealthcare Community Plan will work closely with the DDD Support Coordinator to ensure members transition to the most appropriate care setting.

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

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. 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
- Loss of speech
- Danger of losing life or limb
- Chest pain
- Severe pain in your stomach area
- Poisoning or overdose of medicine or drugs
- 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
- Miscarriage (when a pregnant woman loses her baby)
- Strong feeling that you might hurt yourself or another person
- Faint or pass out for no reason (will not wake up)

If you are not sure it's a real emergency, call your PCP. If you do go to an emergency room, call your PCP as soon as you can after your visit so you can get the right care. Prior authorization is not required for emergency care.

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.

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

Non-emergent hospital services

Non-emergent hospital services are covered when arranged by an in-network physician at a participating facility. Your in-network physician will make these arrangements if medically necessary.

Non-emergency transportation

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. AHCCCS Complete Care and DD members may receive non-emergency transportation services through UnitedHealthcare Community Plan for AHCCCS covered services. You are responsible for setting up your own transportation. 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 Medical Transportation Brokerage of Arizona (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.

If you have a life-threatening emergency and need emergency transportation, call **911**.

Non-emergent transportation is not for emergencies.

DD members:

If you are getting behavioral health services through a TRBHA, you are covered to receive transportation services only to your first TRBHA appointment by your health plan. After your first visit, your TRBHA should transport you for behavioral health services.

Covered health care services

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

UnitedHealthcare reviews new procedures, devices, and drugs to decide if they are safe and effective for members. If they are found to be safe and effective, they may become covered. If new technology becomes a covered service, it will follow plan rules, including medical necessity.

Covered service	AHCCCS Complete Care	DD
Adaptive aids	X	X
AHCCCS-approved organ and tissue transplants and related prescriptions	X	X
Augmentative and Alternative (AAC) Device	X	X
Bariatric Surgery	X	X
Behavioral health services	X	X
Breast reconstruction (post-mastectomy)	X	X
Certain specialized durable medical equipment	X	X
Counseling services	X	X
Dental care – Emergency (members 21 and older have a \$1,000/year limit)	X	X

AHCCCS Complete Care and Developmental Disabilities Member Handbook

Covered service	AHCCCS Complete Care	DD
Dental care – Routine preventive and therapeutic services for ACC and DD members under age 21 (DD members 21 and older have a \$1,000/year limit) See page 54 for additional dental benefit information.	X	X
Dialysis	X	X
Doctor office and specialist visits	X	X
Durable medical equipment and supplies (This will include augmentative communication devices. A PCP referral to a specialist is needed. The specialist will submit a prior authorization request for approval)	X	X
Emergency care and services	X	X
Emergency eye care. Cataract removal and follow-up services	X	X
Emergent/Non-Emergent transportation*	X	X
Family planning services and supplies	X	X
Genetic testing and counseling*	X	X

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

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

AHCCCS Complete Care and Developmental Disabilities Member Handbook

Covered service	AHCCCS Complete Care	DD
Health risk assessments and screenings	X	X
Hearing aids (members under 21)	X	X
Hearing exams	X	X
Human Immunodeficiency Virus (HIV)/AIDS testing, counseling and treatment	X	X
Home health services (such as nursing and home health aide)	X	X
Hospice services	X	X
Hospital care	X	X
Immunizations (shots)	X	X
Incontinence briefs (available for ages 3 years and older when certain medical criteria are met)	X	X
Laboratory	X	X
Lung volume reduction surgery (LVRS): LVRS, or reductive pneumoplasty is covered for persons with severe emphysema, covered when medically necessary.	X	X
Maternity care (prenatal, labor and delivery, postpartum)	X	X
Medical foods (total parenteral nutrition)	X	X

Questions? Visit UHCommunityPlan.com, 29
or call Member Services at 1-800-348-4058, TTY 711.

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AHCCCS Complete Care and Developmental Disabilities Member Handbook

Covered service	AHCCCS Complete Care	DD
Medically necessary surgical services*	X	X
Nursing home (skilled) up to 90 days a year for ACC. No benefit limitation for DD.	X	X
Nursing home (custodial)		X
Nutritional assessments	X	X
Orthotics are covered for members under the age of 21 when prescribed by the member's Primary Care Provider, attending Physician, or Specialist.	X	X
Orthotics are covered for members who are 21 years of age and older when: <ul style="list-style-type: none"> • The orthotic is medically necessary as the preferred treatment based on Medicare guidelines, AND • The orthotic costs less than all other treatments and surgery procedures to treat the same condition, AND • The orthotic is ordered by a physician (doctor) or Primary Care Practitioner (nurse practitioner or physician assistant). 	X	X

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

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

AHCCCS Complete Care and Developmental Disabilities Member Handbook

Covered service	AHCCCS Complete Care	DD
Personal emergency alert system		X
Podiatry services, AHCCCS/DDD covers medically necessary foot and ankle care, including reconstructive surgeries, provided by a licensed podiatrist or other qualified licensed practitioner or physician	X	X
Prescriptions and some over-the-counter medicines to meet special needs if prescribed by your doctor	X	X
Prescriptions on UnitedHealthcare Community Plan's list of covered medicines and prescribed by your doctor	X	X
Preventive services including, but not limited to, screening services such as cervical cancer screening including pap smear, mammograms, colorectal cancer, and screening for sexually transmitted infections	X	X
Private Duty Nurse	X	X
Radiology and medical imaging	X	X
Respiratory therapy	X	X
Respite care up to 600 hours per contract year from Oct. 1 – Sept. 30	X	X

Questions? Visit UHCCommunityPlan.com, 31
or call Member Services at 1-800-348-4058, TTY 711.

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Covered service	AHCCCS Complete Care	DD
Telehealth visits: over the phone or video	X	X
Transplantation of organs and tissue and related medications covered for members with specified medical conditions. <ul style="list-style-type: none"> • Transplant services and medications when medically necessary, must be pre-authorized • Transplants must be done at an AHCCCS approved transplant center 	X	X
Urgent care	X	X
Well visits (well exams) such as, but not limited to, well woman exams, breast exams, and prostate exams, are covered for members. Most well visits (also called checkup or physical) include a medical history, physical exam, health screenings, health counseling and medically necessary immunizations. Early Periodic Screening, Diagnostic, and Treatment (EPSDT) visits for members under 21 years of age are considered the same as a well visit.	X	X

AHCCCS Complete Care and Developmental Disabilities Member Handbook

Covered service	AHCCCS Complete Care	DD
Therapies covered for members who are 21 years of age and older		
Occupational therapy Inpatient	Covered when medically necessary	Covered when medically necessary
Occupational therapy Outpatient	<ul style="list-style-type: none"> • 15 visits per benefit year (10/01–09/30) 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 (10/01–9/30) to reach or obtain a skill or function never learned or developed and maintain that function once developed. 	<ul style="list-style-type: none"> • 15 visits per benefit year (10/01–09/30) 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 (10/01–9/30) to reach or obtain a skill or function never learned or developed and maintain that function once developed.
Physical therapy Inpatient	Covered when medically necessary	Covered when medically necessary

AHCCCS Complete Care and Developmental Disabilities Member Handbook

Covered service	AHCCCS Complete Care	DD
Physical therapy Outpatient	<ul style="list-style-type: none"> • 15 visits per benefit year (10/01–09/30) 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 (10/01–9/30) to reach or obtain a skill or function never learned or developed and maintain that function once developed. 	<ul style="list-style-type: none"> • 15 visits per benefit year (10/01–09/30) 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 (10/01–9/30) to reach or obtain a skill or function never learned or developed and maintain that function once developed.
Speech therapy Inpatient	Covered when medically necessary	Covered when medically necessary
Speech therapy Outpatient	Not a covered benefit	Covered when medically necessary

Additional services for children under 21

Chiropractic services	X	X
Cochlear implants and maintenance	X	X
Conscious sedation (medicine to relieve pain during a medical procedure while the patient is awake)	X	X
Dental care – Routine preventive and therapeutic dental services	X	X
Hearing aids	X	X

AHCCCS Complete Care and Developmental Disabilities Member Handbook

Covered service	AHCCCS Complete Care	DD
Health risk assessments and screening (including EPSDT services)	X	X
Outpatient and inpatient speech, occupational, and physical therapy	X	X
Vision services including eye exams, frames and lenses, replacement and repair of broken or lost eyeglasses without restriction are covered. Cataract removal and follow-up services are covered if approved.	X	X

Additional services for Qualified Medicare Beneficiaries (QMB)

Any services covered by Medicare but not by AHCCCS (see your Medicare handbook)	X	X
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DD members:

For for a list of covered services by DDD, please visit their website at:
 Available DDD Services & Supports | Arizona Department of Economic Security (az.gov)
 or call your DDD Support Coordinator can be reached by calling 1-844-770-9500, Option 1.

Non-covered health care services

All members

- Cosmetic services or items (except for CRS conditions)
- Services that are not medically necessary
- Medical services for those in an institution for TB (tuberculosis) treatment
- Over-the-counter medicines and medical supplies (except under certain conditions). Refer to the UnitedHealthcare Over-the Counter Drug List for a list of products available on our website at: [UHCCCommunityPlan.com](https://www.uhccommunityplan.com) or call Member Services to request a printed copy.
- Personal care items such as combs, razors, soap, etc.
- Pregnancy termination unless the pregnancy is the result of rape or incest, a physician decides that it is medically necessary because the pregnancy will cause a serious physical or mental health problem for the pregnant member, or continuing the pregnancy is life-threatening
- Prescriptions not on our list of covered medications, unless approved
- Reversal of voluntary sterilization
- Routine circumcisions
- Services from a provider who is not contracted with UnitedHealthcare Community Plan (unless prior approved by the health plan). If you have other insurance, you can see a non-contracted provider. If you are unsure, call UnitedHealthcare Community Plan Member Services.
- Services from a provider who is not registered with AHCCCS
- Services that are determined to be experimental by the health plan Medical Director
- Sex change operations
- Treatment to straighten teeth, unless medically necessary and approved by UnitedHealthcare Community Plan
- Room and board in assisted living facilities and behavioral health group homes
- Medical marijuana – AHCCCS does not cover medical marijuana as a medical or pharmacy benefit

Other non-covered services for adults (age 21 and over)

- Chiropractic services (except for QMB members)
- Cochlear implant
- Hearing aids and bone-anchored hearing aids
- Lower limb micro-processor controlled joint
- Routine dental services except for DD members. See **Dental care** section for more information.
- Routine eye examinations for prescriptive lenses or glasses

If you have any questions if a service is covered or not, talk to your PCP or call Member Services.

Accessing Non-Title XIX/XXI services

Non-Title XIX/XXI services, based on the availability of funding. Non-Title XIX/XXI services include:

- 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.
- Childcare supportive services are covered when providing medically necessary Medicated Assisted Treatment or outpatient (non-residential) treatment or other supportive services for SUD to Members with dependent children, when the family is being treated as a whole
- 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.
- Mental Health Services, Room and Board. Lodging and meals to an individual residing in a residential facility or supported independent living setting which may include but is not limited to:
 - a. Housing costs,
 - b. Services such as food and food preparation,
 - c. Personal laundry, and
 - d. Housekeeping.

These services are available to members through a referral to the RBHA located in the member's county. Members can access Non-Title XIX/XXI services, by calling Member Services. Member Services will send the request to our Behavioral Health Coordinators for both general mental health and SMI. The Behavioral Health Coordinators work directly with the designated RBHA Liaison to set-up the needed services and will outreach the member directly to help coordinate care.

Housing services

Housing Assistance and resources are available to all members. UnitedHealthcare Community Plan members are eligible for assistance in overcoming their particular housing needs. We cannot guarantee any housing placement. However, we can assess housing needs and provide referrals to housing resources within the community.

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 apartment. Members can obtain basic information about affordable housing and shelters in the links below.

In addition to the housing resources available in the community, AHCCCS oversees several permanent supportive housing programs throughout Arizona. The AHCCCS Housing Program supports members with a designation of Serious Mental Illness (SMI) and some services are provided for members with a General Mental Health and/or Substance Use Disorder (GMHSUD). Contact your Behavioral Health provider to determine if you are eligible for a referral to the AHCCCS Housing Program. These referrals are made by your provider as part of an individual service plan, based on medical necessity.

How can someone experiencing homelessness obtain services?

Any member reporting as homeless should follow up with the Coordinated Entry System Access Point to be assessed for housing interventions. The goals of coordinated entry are to increase the efficiency of a local crisis response system and improve fairness and ease of access to services, including housing and mainstream benefits.

Listed below are the Coordinated Entry Access Points in Maricopa, Pima, Pinal and Gila counties. Housing interventions are determined by the VI-SPDAT. The tool is designed to be quick and effective. The VI-SPDAT usually takes less than 10 minutes and is used to determine what intervention would be most useful to the person/family experiencing homelessness. Coordinated entry can get members connected to shelters and also help with additional housing interventions if the member is eligible.

Coordinated Entry Access Points for members who report as homeless

Refer members experiencing homelessness or risk of homelessness to the HEARTH Continuum of Care (CoC) program through the local Coordinated Entry system in their community. The following links give more information about the services available in each region.

- Arizona Balance of State CoC The Arizona Department of Housing serves as the Collaborative Applicant and Homeless Management Information System (HMIS) lead agency for the CoC for the 13 non-metro counties in the state. Locate community access points by county by visiting: <https://housing.az.gov/general-public/homeless-assistance>.
- Tucson/Pima County CoC Tucson Pima Collaboration to End Homelessness (TPCH) is a coalition of community and faith-based organizations, government entities, businesses and individuals committed to the mission of ending homelessness and addressing the issues related to homelessness in our community. Locate community access points by visiting: <https://tpch.net/coordinatedentry/>.
- Phoenix/Mesa/Maricopa County Regional CoC is staffed by the Maricopa Association of Governments. More than 40 homeless assistance programs in 13 different agencies are supported. Locate community access points by visiting: <https://maricopahousing.org/wp-content/uploads/2021/07/Coordinated-Entry-Points-Handout.pdf>.

Housing resources:

Arizona Department of Housing **602-771-1000**

Income-based housing:

- Subsidized apartment search:
<https://resources.hud.gov> / Subsidized apartment search
- Public Housing Authorities:
https://www.hud.gov/program_offices/public_indian_housing/pha/contacts
- Housing Choice Vouchers (Section 8):
https://www.hud.gov/topics/housing_choice_voucher_program_section_8
- Section 202 Supportive Housing for the Elderly:
https://www.hud.gov/program_offices/housing/mfh/grants/section202ptl
- Section 811 Supportive Housing for Persons with Disabilities:
https://www.hud.gov/program_offices/housing/mfh/grants/section811ptl

Sober living housing:

- AZ Recovery Housing Association Certified Sober Living Communities
<https://myazrha.org/landing/>

Eviction prevention resources:

- Emergency Rental Assistance:
<https://www.consumerfinance.gov/coronavirus/mortgage-and-housing-assistance/renter-protections/find-help-with-rent-and-utilities/>
- HUD Approved Housing Counseling Agencies:
<https://apps.hud.gov/offices/hsg/sfh/hcc/hcs.cfm?&webListAction=search&searchstate=AZ>

Department of Housing & Urban Development subsidized apartment search tool:

- <https://resources.hud.gov/>

To receive additional information regarding these programs or to contact the Housing Specialist/Coordinator, contact Member Services at **1-800-348-4058**.

Residential placement

Out of home 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.

Behavioral health residential facility:

Health care institution that provides treatment to an individual experiencing a behavioral health issues that:

- a. Limits the individuals ability to be independent, or
- b. Causes the individual to require treatment to maintain or enhance independence.

Home care training to home care client (HCTC or therapeutic foster care):

Are delivered to members whose behavioral health needs are of such a critical nature that in the absence of such services the member would be at risk of transitioning into a more restrictive residential setting such as a hospital, psychiatric center, correctional facility, residential treatment program or a therapeutic group home.

DD members:

DD members may be eligible for Alternative Home and Community Based Services (HCBS). Please work with your Support Coordinator to qualify and obtain these services. Your DDD Support Coordinator can be reached by calling 1-844-770-9500, Option 1.

End of Life Care

End of Life (EOL) care is a member-centered approach with the goal of preserving member rights and maintaining member dignity while receiving any other medically necessary covered services, while providing relief of stress, pain, or life limiting effects of illness to improve the quality of life. EOL care includes providing you and your family with information about your illness and treatment choices. EOL care allows you to receive Advance Care Planning, palliative care, supportive care and practical care services. Members who receive EOL care can choose to receive curative care until they choose to receive hospice care.

DD members:

If you need assistance with End of Life care (EOL) or Advance Care Planning, call your DDD Support Coordinator to coordinate. Your DDD Support Coordinator can be reached by calling 1-844-770-9500, Option 1.

Seeing a specialist or other providers

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 and members with special health care needs may also request services without a referral or prior authorization 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

AHCCCS Complete Care and Developmental Disabilities Member Handbook

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.

You may also find provider information such as:

- Name, address and phone numbers
- Professional qualifications
- Medical school attended (by phone only)
- Residency completion (by phone only)
- Board certification status
- Languages spoken
- Age group served
- Hospital affiliations
- If accepting new patients
- Wheelchair accessibility

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 Member Services.

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.

Your Primary Care Physician (PCP)

Your health care is important to us. We carefully screen and pick our doctors so you receive the best care. When you enroll, you will be assigned a Primary Care Physician (PCP). Your PCP is your personal care doctor. Your PCP will provide or arrange the covered services you need. Make sure you talk to your PCP about any health problems you have. That way, your PCP gets to know you and your medical history. Always follow your PCP's instructions and get approval before you get any medical services. Be sure and tell your PCP about any behavioral health issues as well. Your PCP may be able to treat behavioral health conditions or you may get behavioral health services without a referral. **If you are pregnant, you may choose your Maternity Care Provider as your primary physician**, or you may choose a 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.

Changing your PCP

Your PCP is an important part of your health care team. You and your PCP need to work together. If for any reason you want to change your PCP, call Member Services. If you change your PCP, you must choose another PCP from the UnitedHealthcare Community Plan Provider Directory. We can help you choose a new PCP or tell you more about the PCPs in our network. If you are pregnant, contact Healthy First Steps at 1-800-599-5985. Member Services can send you a list of our providers at no cost to you. **If your PCP does not speak your language, call Member Services. UnitedHealthcare Community Plan will provide you with interpreter services at no cost to you.**

Making appointments

It is important for you to set up an appointment before you arrive at your PCP's office. When you call the PCP's office, tell them you are a UnitedHealthcare Community Plan member and why you need an appointment. If you don't make an appointment and just show up, your PCP may not be able to see you. Routine appointments can be scheduled with your PCP within 21 calendar days of request. Once you get to the office, your doctor will try to see you within 45 minutes. You may have to wait longer if there is an emergency. If you need urgent care, your PCP should see you within 2 business days of request. If you need emergency care, your PCP should see you that day, if they are unable to see you they may refer you to an urgent care or emergency room. For life-threatening emergencies, call 911 or go to the nearest emergency room.

Canceling or changing appointments

If you need to cancel or change your appointment, tell your PCP's office at least one day before the appointment. This lets the doctor see other patients. If you cancel an appointment, be sure to make another appointment for a different time.

Well visits

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

Women's preventive care services

Well-woman preventative care visits are covered for members on an annual basis. The well woman preventive care visit includes the following services:

- A physical exam (Well Exam) that assesses overall health
- Clinical breast exam
- Pelvic exam (as necessary, according to current recommendations and best standards of practice)
- Review and administration of immunizations, screenings, and testing as appropriate for age and risk factors
 - Human Papillomavirus (HPV) vaccines are covered as recommended by the Centers for Disease (CDC) <https://www.cdc.gov/hpv/parents/vaccine-for-hpv.html>
- Screening and counseling focused on maintaining a healthy lifestyle and minimizing health risks and addresses at a minimum the following:
 - Proper nutrition
 - Physical activity
 - Elevated BMI indicative of obesity
 - Tobacco/substance use, abuse, and/or dependency
 - Depression screening
 - Interpersonal and domestic violence screening, that includes counseling about current or past violence and abuse and addresses current or future health concerns about safety
 - Sexually transmitted infections
 - Human Immunodeficiency Virus (HIV)
 - Family planning services and supplies
- Preconception counseling that includes discussion regarding a healthy lifestyle before and between pregnancies that includes:
 - Reproductive history and sexual practices,
 - Healthy weight, including diet and nutrition, as well as the use of nutritional supplements and folic acid intake,
 - Physical activity or exercise,
 - Oral health care,
 - Chronic disease management,
 - Emotional wellness,

- Tobacco and substance use (caffeine, alcohol, marijuana, and other drugs), including prescription drug use, and
- Recommended breaks between pregnancies.
- Initiation of necessary referrals when the need for further evaluation, diagnosis, and/or treatment is identified

Well visits for children and members up to age 21

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

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

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

Amount, duration and scope:

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

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

This means that EPSDT covered services include services that correct or ameliorate physical and behavioral health conditions, and illnesses discovered by the screening process when those services fall within one of the optional and mandatory categories of “medical assistance” as defined in the Medicaid Act. Services covered under EPSDT include all 30 categories of services in the federal law even when they are not listed as covered services in the AHCCCS state plan, AHCCCS statutes, rules, or policies as long as the services are medically necessary and cost effective.

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

Pregnancy/maternity 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. Healthy First Steps engages and rewards members for keeping prenatal and postpartum care appointments through the infant's first 15 months of life. 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 or visit our website at UHHealthyFirstSteps.com.

Female members, or members assigned female at birth, have direct access to preventive and well care services from a gynecologist or other maternity care provider within 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.

Noninvasive pregnancy testing for high risk pregnancies are covered.

As a member, UnitedHealthcare Community Plan will help you:

- Choose a Maternity Care Provider, licensed physician, nurse practitioner, physician assistant, Certified Nurse Midwife (CNM), or Licensed Midwife (LM) for pregnancy care
- Get information about Healthy First Steps — a maternity program for you and your baby where you can earn rewards for completing prenatal and postpartum care appointments. You can call Healthy First Steps at 1-800-599-5985 or enroll online at <http://www.uhhealthyfirststeps.com>.
- 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 as well as help with scheduling medically necessary transportation

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- Choose a pediatrician (child’s doctor) or a family medicine 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 send email to 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 services and supplies after your baby’s birth (including but not limited to birth control pills, condoms, long-acting reversible contraceptives 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 requires, but no later than 3 business days of identification of high risk by UnitedHealthcare Community Plan 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 Maternity Care Provider 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 60 days after your baby’s birth (postpartum care). If you had a cesarean section, your doctor may want to see you sooner.

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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

Knowing all your options for birth control can help you choose the right method for you. Long-acting Reversible Contraceptive (LARC) options are a good choice for many women (including placement of Immediate Postpartum Long-Acting Reversible Contraceptives [IPLARC]), and there is no copay, 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.

Any member can have a Human Immunodeficiency Virus (HIV) test at any time. If you are pregnant and have HIV, the virus can be passed to your fetus. The good news is that treatment during pregnancy and treating the baby after birth can greatly reduce the chance of this happening. Treatment during pregnancy can also help you stay healthy. If your test is positive, you can get specialty treatment and medical counseling. Talk to your PCP, Maternity Care Provider or contact your local department of public health for testing. HIV/STI testing are available at the Arizona Family Partnership **602-258-5777** or **1-888-272-5652** or visit the website at www.arizonafamilyhealth.org. Planned Parenthood also offers testing and services. Call **1-800-230-7526**.

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 Health Plans” earlier in this handbook.

If you find out you are no longer pregnant, call 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 the number on your ID card. Please see page 9 of this handbook for behavioral health crisis information and pages 58–67 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.

If experiencing a behavioral health crisis call:

Crisis hotlines by county:

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
Tohono O’Odham Nation	1-844-423-8759

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

Family planning services and supplies

Family planning services and supplies help you protect yourself from having an unwanted pregnancy and/or contracting a sexually transmitted infection (STI) or a sexually transmitted disease (STD). Both men and women regardless of gender, who voluntarily chose to delay or prevent pregnancy, are eligible to receive family planning services and supplies. When requirements are met, sterilization services are covered regardless of member's gender.

For family planning services and supplies, you may choose a maternity care or family planning provider such as a physician, nurse practitioner, physician's assistant, nurse midwife, or midwife, without a referral, and regardless of whether or not the family planning service providers are network providers. Family planning services are also available from any Planned Parenthood (1-800-230-7526) office statewide. Family planning services and supplies do not require a referral, may be supplied by non-contracted AHCCCS registered providers, and are offered at no copayment and no cost to you. Medically necessary transportation services are available.

Knowing all your options for birth control can help you choose the right method for you. Long-acting Reversible Contraceptive (LARC) options are a good choice for many women (including placement of Immediate Postpartum Long-Acting Reversible Contraceptives [IPLARC]), and there is no copay, 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.

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In addition to the IUD and birth control implant, covered family planning services and supplies also include but are not limited to the following:

- Birth control pills: Pill taken every day
- Condoms (rubbers)
- Depo Provera: Shot given every three 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
- Family planning lab services
- Hysteroscopic tubal sterilization
- Medical and laboratory exams
- Natural family planning education
- 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, or you may 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.

Regardless of gender, 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 care

We feel that dental care is just as important as other care you receive. That's why we assign our members under the age of 21 to a dental home. This is like your PCP, but for dental care. You would see this dentist for your routine dental care. Your dental home assignment will be mailed to you. Call this dentist to make, cancel, or change an appointment. If you did not receive or have misplaced your dental home assignment information, you can call Member Services.

Our Member Services team can provide your dental home information to you. They can also help you change your dental home assignment.

For urgent dental appointments members will be seen as soon as the member's health condition requires, but no later than 3 business days of request. Routine appointments are within 45 calendar days of request. For urgent dental specialty provider appointments, member's will be seen as soon as the member's health condition requires, but no later than 2 business days from the request. Routine specialty appointments are within 45 calendar days of request. To find a dentist or dental specialist visit UHCommunityPlan.com or call Member Services at **1-800-348-4058**.

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

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

Members 21 years of age and older may receive emergency dental services of up to \$1,000 for each 12-month period beginning October 1st through September 30th.

DD members:

Age 21 and over have a \$1,000 benefit for routine dental services including dentures and a \$1,000 benefit for emergency dental services for each 12-month period beginning October 1st through September 30th. We also assign DD members age 21 and over to a dental home. You can see this dentist for your routine dental care. You can change your dental home by calling Member Services at **1-800-348-4058**.

For individuals with an intellectual disability who reside in an intermediate care facility (ICF/IDD) UnitedHealthcare Community Plan provides all medically necessary dental services including emergency dental services, dental screenings, preventative services, therapeutic services and dental appliances.

Getting your prescriptions (medications)

Getting prescription medications is an important part of your health care. If your AHCCCS registered 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 medication is not listed on the PDL, your care provider may request an alternative medication 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, or to look up medications on the Preferred Drug List, 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.

Medicaid does not cover medications eligible for coverage under Medicare Part D or Medicare copayments, coinsurance, or deductibles for Medicare Part D medications. Unless, you are only enrolled in Medicare Part A and have credible prescription drug coverage.

Prior approval

Prior approval (authorization) of prescription medications.

If your prescription medication 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 medication. 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 medication 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 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. This is called an exclusive pharmacy.

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:

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Over-utilization	<p>Member utilized the following in a 3 month time period:</p> <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. <p>OR</p> <p>Member has received 12 or more prescriptions of the medications of concern (drugs with abuse potential) in the past three months.</p>
Fraud	<p>Member has presented a forged or altered prescription to the pharmacy.</p>

Behavioral health services

We are concerned about how you feel. Behavioral health services can help you with personal problems that may affect you and/or your family. These problems may be stress, depression, anxiety or using drugs or alcohol.

AHCCCS Complete Care and DD members assigned to UnitedHealthcare Community Plan will receive all of their behavioral health care from UnitedHealthcare Community Plan with the exception of the first 23 hours of crisis care (see page 9) and some care for members determined to have serious mental illness.

If you have questions or need help getting behavioral health services, please call the number on your ID card.

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, 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 family, health care decision maker or designated 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.

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Some members may qualify for Non-Title XIX/XXI services such as: room and board, mental health services (formerly known as traditional healing), auricular acupuncture, and supported housing rent/utility subsidies and relocation services. These services are available to members through a referral to the RHBA located in the member's county.

A Serious Mental Illness (SMI) is a chronic and long term mental health condition which impacts a person's ability to perform day-to-day activities or interactions. SMI qualifying diagnoses include: Psychotic Disorders, Bipolar Disorders, Obsessive-Compulsive Disorder, Depressive Disorder, Other Mood Disorders, Anxiety Disorders, Post Traumatic Stress Disorder, Dissociative Disorder and Personality Disorders.

SMI eligibility evaluation can be obtained at any qualifying AHCCCS behavioral health intake provider. Please call Member Services at **1-800-348-4058** for more information on how to be connected with a qualified AHCCCS behavioral health provider. 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 Solari Crisis & Human Services within 3 business days of the assessment. Solari Crisis & Human Services is the designated entity responsible for managing all SMI eligibility determination appeals. All other behavioral health related appeals are processed by UnitedHealthcare Community Plan. Solari Crisis & Human Services will provide written notice of their decision with appeal instructions if the member disagrees with their decision. For more information about Solari Crisis & Human Services timelines visit: <https://crisis.solari-inc.org> or you can call Solari Crisis & Human Services at 1-855-832-2866.

If an ACC 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 determined to have 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, care manager, or contact AHCCCS Office of Human Rights at 1-800-421-2124.

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The chart below will show you who provides your behavioral health services

Program	Behavioral health provider
AHCCCS Complete Care	UnitedHealthcare Community Plan
AHCCCS Complete Care (SMI Opt-Out)	RBHA or TRBHA
Developmental Disabilities including SMI	UnitedHealthcare Community Plan or TRBHA

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 but no later than 45 calendar days.

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

For behavioral health 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.

Behavioral health services you may be eligible for include, but are not limited to:

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

60 **Questions?** Visit [UHCCCommunityPlan.com](https://www.uhc.com/communityplan), 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
- Lab and radiology services
- Partial care (supervised day program, therapeutic day program, specialized outpatient substance use program and medical day program)
- Peer and family support
- Psychosocial rehabilitation (living skills training, health promotion; supported employment services)
- 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 the behavioral health number on your ID card, use your provider directory or visit our website at [UHCommunityPlan.com](https://www.uhc.com/communityplan).

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 statewide crisis line: 1-844-534-HOPE (4673).

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 50 of this handbook or call the Substance Use Disorder Helpline directly.

Sanvello

On-demand help with stress, anxiety and depression

Sanvello is an app that offers clinical solutions to help dial down the symptoms of stress, anxiety and depression — anytime. Connect with powerful tools that are there for you when symptoms come up. Stay engaged for each day for benefits you can feel. Use Sanvello whenever you need to, track your progress and stay until you feel better. You can upgrade to premium at no cost by following these steps:

1. Download the app at sanvello.com and open it.
2. Create an account and choose “upgrade through insurance.”
3. Search for and select **UnitedHealthcare**, then enter the information available on your UnitedHealthcare medical insurance card.

Download today

More information is available at sanvello.com. Email info@sanvello.com with any questions.

Arizona’s vision for the delivery of behavioral health services

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

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

The 12 principles for the delivery of services to children

1. Collaboration with the child and family:

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

2. Functional outcomes:

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

3. Collaboration with others:

- a. When children have multi-agency, multi-system involvement, a joint assessment is developed and a jointly established behavioral health services plan is collaboratively implemented,
- b. Client-centered teams plan and deliver services,
- c. Each child's team includes the child and parents and any foster parents, any individual important in the child's life who is invited to participate by the child or parents. The team also includes all other persons needed to develop an effective plan, including, as appropriate, the child's teacher, the child's Division of Child Safety (DCS) and/or Division of Developmental Disabilities (DDD) caseworker, and the child's probation officer, 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.

5. Best practices:

- a. Behavioral health services are provided by competent individuals who are trained and supervised,
- b. Behavioral health services are delivered in accordance with guidelines that incorporate evidence-based “best practices,”
- c. Behavioral health service plans identify and appropriately address behavioral symptoms that are related to: learning disorders, substance use problems, specialized behavioral health needs of children who are developmentally disabled, history of trauma (e.g. abuse or neglect) or traumatic events (e.g. death of a family member or natural disaster), maladaptive sexual behavior, abusive conduct and risky behaviors. Service plans shall also address the need for stability and promotion of permanency in class members’ lives, especially class members in foster care, and
- d. Behavioral health services are continuously evaluated and modified if ineffective in achieving desired outcomes.

6. Most appropriate setting:

- a. Children are provided behavioral health services in their home and community to the extent possible, and
- b. Behavioral health services are provided in the most integrated setting appropriate to the child’s needs. When provided in a residential setting, the setting is the most integrated and most home-like setting that is appropriate to the child’s needs.

7. Timeliness:

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

8. Services tailored to the child and family:

- a. The unique strengths and needs of children and their families dictate the type, mix, and intensity of behavioral health services provided, and
- b. Parents and children are encouraged and assisted to articulate their own strengths and needs, the goals they are seeking, and what services they think are required to meet these goals.

9. Stability:

- a. Behavioral health service plans strive to minimize multiple placements,
- b. Service plans identify whether a class member is at risk of experiencing a placement disruption and, if so, identify the steps to be taken to minimize or eliminate the risk,
- c. Behavioral health service plans anticipate crises that might develop and include specific strategies and services that will be employed if a crisis develops,
- d. In responding to crises, the behavioral health system uses all appropriate behavioral health services to help the child remain at home, minimize placement disruptions, and avoid the inappropriate use of the police and the criminal justice system, and
- e. Behavioral health service plans anticipate and appropriately plan for transitions in children's lives, including transitions to new schools and new placements, and transitions to adult services.

10. Respect for the child and family's unique cultural heritage:

- a. Behavioral health services are provided in a manner that respects the cultural tradition and heritage of the child and family, and
- b. Services are provided in Spanish to children and parents whose primary language is Spanish.

11. Independence:

- a. Behavioral health services include support and training for parents in meeting their child's behavioral health needs, and support and training for children in self-management, and
- b. Behavioral health service plans identify parents' and children's need for training and support to participate as partners in the assessment process, and in the planning, delivery, and evaluation of services, and provide that such training and support, including transportation assistance, advance discussions, and help with understanding written materials, will be made available.

12. Connection to natural supports:

- a. The behavioral health system identifies and appropriately utilizes natural supports available from the child and parents' own network of associates, including friends and neighbors, and from community organizations, including service and religious organizations.

Nine guiding principles for recovery-oriented adult behavioral health services and systems

1. Respect.

Respect is the cornerstone. Meet the person where they are without judgment, with great patience and compassion.

2. Persons in recovery choose services and are included in program decisions and program development efforts.

A person in recovery has choice and a voice. Their self-determination in driving services, program decisions and program development is made possible, in part, by the ongoing dynamics of education, discussion, and evaluation, thus creating the “informed consumer” and the broadest possible palette from which choice is made. Persons in recovery should be involved at every level of the system, from administration to service delivery.

3. Focus on individual as a whole person, while including and/or developing natural supports.

A person in recovery is held as nothing less than a whole being: capable, competent, and respected for their opinions and choices. As such, focus is given to empowering the greatest possible autonomy and the most natural and well-rounded lifestyle. This includes access to and involvement in the natural supports and social systems customary to an individual’s social community.

4. Empower individuals taking steps toward independence and allowing risk taking without fear of failure.

A person in recovery finds independence through exploration, experimentation, evaluation, contemplation and action. An atmosphere is maintained whereby steps toward independence are encouraged and reinforced in a setting where both security and risk are valued as ingredients promoting growth.

5. Integration, collaboration, and participation with the community of one’s choice.

A person in recovery is a valued, contributing member of society and, as such, is deserving of and beneficial to the community. Such integration and participation underscores one’s role as a vital part of the community, the community dynamic being inextricable from the human experience. Community service and volunteerism is valued.

6. Partnership between individuals, staff, and family members/natural supports for shared decision making with a foundation of trust.

A person in recovery, as with any member of a society, finds strength and support through partnerships. Compassion-based alliances with a focus on recovery optimization bolster self-confidence, expand understanding in all participants, and lead to the creation of optimum protocols and outcomes.

7. Persons in recovery define their own success.

A person in recovery — by their own declaration — discovers success, in part, by quality of life outcomes, which may include an improved sense of well-being, advanced integration into the community, and greater self-determination. Persons in recovery are the experts on themselves, defining their own goals and desired outcomes.

8. Strengths-based, flexible, responsive services reflective of an individual's cultural preferences.

A person in recovery can expect and deserves flexible, timely, and responsive services that are accessible, available, reliable, accountable, and sensitive to cultural values and mores.

A person in recovery is the source of his or 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 who have been designated as having a Children’s Rehabilitative Services (CRS) diagnosis can see their medical and behavioral health specialists and any others involved in their care, all at one location. When CRS Designated members turn 21 they will no longer be designated as CRS. However, may continue to receive care at the MSIC. All members can be seen at the MSIC, not just those with a CRS diagnosis. 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

MSICs are at the following locations:

DMG Children's Rehabilitative Services

3141 North 3rd Avenue

Phoenix, AZ 85013

602-914-1520

855-598-1871

Children's Health Center

5130 N Highway 89A

Flagstaff, AZ 86004

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, ext. **45437**

Children's Rehabilitative Services

2851 South Avenue B

Building 25 #2504

Yuma, AZ 85364

928-336-2777

800-837-7309

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.

Questions? Visit UHCCommunityPlan.com, 69
or call Member Services at **1-800-348-4058**, TTY **711**.

AHCCCS Complete Care and Developmental Disabilities Member Handbook

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.

The Member Advocacy Council (MAC)

The Member Advocacy Council is a partnership between UnitedHealthcare Community Plan, our members, member families, other stakeholders, and community advocacy organizations. MAC members meet every two months to provide input about service delivery, member communications and materials, and person-centered resources. Members and member families from UnitedHealthcare Community Plan are recruited for membership on the MAC. The MAC provides the opportunity for members or their families to meet with other UnitedHealthcare Community Plan members and staff to share and discuss ideas and information on how they are experiencing care as a member.

If you would like to become involved in MAC activities, please send an email to advocate.OIFA@uhc.com or contact Member Services at **1-800-348-4058**.

The Developmental Disabilities Advisory Council (DDAC)

The Developmental Disabilities Advisory Council (DDAC) is an advisory council who makes recommendations to the Assistant Director of the Division of Developmental Disabilities on matters relating to developmental disabilities. The mission of the DDAC is to provide, in partnership with the Division of Developmental Disabilities, advisory oversight on behalf of consumers, families and providers.

If you would like to become involved in DDAC activities, please visit <https://des.az.gov/ddac>.

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

Independent Oversight Committees

The Independent Oversight Committees (formerly the Human Rights Committees) are established in accordance with ARS § 41-3801, § 41-3803 and § 41-3804. Each committee is comprised of groups of citizens who provide support and review in matters to the rights of people with developmental disabilities and members who receive behavioral health services. The DES DDD committees by region are: Central, East, North, West, South and Statewide. The AHCCCS committees by region are: Central, Northern, Southern, Statewide and Department of Health Services Arizona State Hospital (DHS ASH). If you would like to become involved in IOC activities please visit <https://ioc.az.gov/independent-oversight-committee-ioc-application>.

Program Review Committee

The Program Review Committee (PRC) reviews any behavior treatment plans that meet the criteria outlined Article 9 Managing Inappropriate Behaviors (Arizona Revised Statutes) regarding managing behaviors that are challenging to others. Members of the committees may include a direct care worker who provides habilitation services, a psychologist, psychiatrist or Board Certified Behavioral Analyst, a parent of an individual with a developmental disability, and others. The PRC reviews and approves behavior treatment plans, or makes recommendations for changes as necessary. If you are interested in participating on a Program Review Committee visit [https://des.az.gov/how-do-i/volunteer](https://des.az.gov/how-do-i-volunteer) or call 602-542-1991.

The Arizona Achieving a Better Life Experience (ABLE) Act Oversight Committee

An Achieving a Better Life Experience (ABLE) account is a savings program to provide persons with disabilities, their family and friends, the option to contribute to a tax-exempt savings account for disability-related expenses. The seven-member Arizona ABLE Act Oversight Committee makes recommendations and provides guidance for the establishment, implementation, and improvement of the program, including statutory and rule changes. For more information visit <https://des.az.gov/services/disabilities/developmental-disabilities/az-able-achieving-better-life-experience/arizona-achieving-better-life-experience-able-act-oversight-committee>.

Arizona Developmental Disabilities Planning Council (ADDPC)

The Arizona Developmental Disabilities Planning Council (ADDPC) provides original research, education, advocacy and financial support to help Arizona residents with developmental disabilities and their families with employment, self-advocacy and community inclusion. Its mission is to develop and support capacity building and systemic change to increase inclusion and involvement of people with developmental disabilities in their communities through the promotion of self-determination, independence and dignity in all aspects of life. For more information call 602-542-8970 or visit <https://addpc.az.gov/about/contact-us>.

Interagency Coordinating Council (ICC) for infants and toddlers

The ICC assists the Department of Economic Security, Arizona Early Intervention Program (DES/AzEIP), to improve early intervention for families and professionals. The ICC helps with the development and implementation of early intervention policies and provides feedback regarding federal, state or local policies that facilitate and/or impede timely service delivery.

If you would like to become involved in ICC activities, please visit <https://des.az.gov/interagency-coordinating-council-for-infants-and-toddlers>.

Utilization Management policy and procedures

We have policies and steps we follow in decision-making about approving medical services. We want to make sure that the health care services provided are medically necessary, right for your condition and are provided in the best care facility. We make sure that quality care is delivered.

The criteria used in our decision-making are available to you and your doctor if you ask for it. No UnitedHealthcare Community Plan employee or provider is rewarded in any way for not giving you the care or services you need or for saying that you should not get them.

A Utilization Management (UM) Decision is when we look at the appropriateness, medical need and efficiency of health care services, procedures and facilities against our set criteria. Included may be: discharge planning, concurrent planning, pre-certification, approval in advance and clinical case appeals. Also, it may cover proactive processes like concurrent clinical review, peer review and appeals from a provider, payer or patient/member. A service shall be considered medically necessary if it prevents, diagnoses, or treats a physical or behavioral health condition or injury, is necessary to achieve age appropriate growth and development, minimizes the progression of disability, or is necessary to attain, maintain, or regain functional capacity.

There are also some treatments and procedures we need to review before you can get them. Your providers know what they are, and they take care of letting us know to review them. The review we do is called a Utilization Review. We do not reward anyone for saying no to needed care. If you have questions about UM, you can talk to our Medicaid Care Management staff. Our nurses are available 24 hours per day/7 days a week by calling 1-877-440-0255, TTY/TDD 1-800-855-2880. Language assistance is available.

Prior authorization 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.

UnitedHealthcare Community Plan: **1-800-348-4058**, TTY/TDD **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. Your PCP or treating physician may request for you to see an out-of-network provider by calling UnitedHealthcare Community Plan: **1-800-348-4058**, TTY/TDD **711**. The out-of-network provider must be registered with AHCCCS and must obtain an authorization for services. Services will be at no cost to you less any possible copay, when UnitedHealthcare Community Plan authorizes the care or service in advance, before you see the 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 UHCCommunityPlan.com.

Freedom of choice

A provider network is a group of providers who contract with UnitedHealthcare Community Plan to provide services. If you'd like to select a provider based on convenience, location or cultural preference, you call Member Services. 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. 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

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

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

The following persons are not asked to pay copayments:

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

****Note:** For a limited time, persons who are eligible in the Adult Group will not have any copays. Members in the Adult Group include persons who were transitioned from the AHCCCS Care program as well as individuals who are between the ages of 19–64, and who are not entitled to Medicare, and who are not pregnant, and who have income at or below 133 percent of the Federal Poverty Level (FPL) and who are not AHCCCS eligible under any other category. Copays for persons in the Adult Group with income over 106 percent FPL are planned for the future. Members will be told about any changes in copays before they happen.

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

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

People with optional (non-mandatory) copayments

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

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

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

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

Ask your provider to look up your eligibility to find out what copays you may have. You can also find out by calling UnitedHealthcare Community Plan Member Services. You can also check the UnitedHealthcare Community Plan website for more information.

AHCCCS Complete Care and Developmental Disabilities Member Handbook

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

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

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

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

People with required (mandatory) copayments

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

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

AHCCCS Complete Care and Developmental Disabilities Member Handbook

Required (mandatory) copayment amounts for persons receiving TMA benefits

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

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

5 percent limit on all copayments

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

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

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

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

DD members:

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 are billed

If you receive a service covered under UnitedHealthcare Community Plan, you should not receive a bill. If you do, call your provider (doctor or hospital) right away. Tell them you have insurance with UnitedHealthcare Community Plan and make sure they have your ID number. Tell the provider to stop billing you and to send a claim to UnitedHealthcare Community Plan.

If you keep getting bills, send us a letter and a copy of your bill to:

UnitedHealthcare Community Plan
Member Services
1 East Washington Street, Suite 900
Phoenix, AZ 85004

We will contact the provider and tell them to stop billing you. If you agree to receive services that are not covered by UnitedHealthcare Community Plan, you may have to pay the bill.

AHCCCS Complete Care and Developmental Disabilities Member Handbook

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 allows a provider to charge 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.

Other insurance and Medicare

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 and AHCCCS. Try to choose a PCP who works with both UnitedHealthcare Community Plan and your other insurance. This will help us coordinate your benefits. If you receive services from a doctor that is not contracted with UnitedHealthcare Community Plan, you must have prior authorization or you will be responsible for payment, including copays, coinsurance, and deductibles.

Members who have both AHCCCS and Medicare are called “dual eligible.” UnitedHealthcare Community Plan may help pay your coinsurance, deductible, and copayment amounts for Medicare Part A and B covered services 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.

Do not pay the doctor directly. If you pay for AHCCCS-covered services directly, we cannot pay you back. **Tell your doctor to bill UnitedHealthcare Community Plan.** Make sure to show the doctor your UnitedHealthcare Community Plan ID card and your other insurance. 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.

If you have questions about how your primary insurance will impact your UnitedHealthcare Community Plan coverage, call Member Services prior to receiving services from your doctor.

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

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. UnitedHealthcare Community Plan may help you pay copays, coinsurance or deductibles that other insurance may charge you.

Medicare prescription drug benefit and AHCCCS members

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

- 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).

Medicaid does not cover medications that are eligible for coverage under Medicare Part D plans. Medicaid does not pay for Medicare copayments, deductibles or cost sharing for Medicare Part D medications except for persons who have been designated to have an SMI designation. AHCCCS covers medications that are excluded from coverage under Medicare Part D when those covered medications are deemed medically necessary. An excluded drug is a medication that is not eligible for coverage under Medicare Part D. AHCCCS may cover some medications that are Over-the-Counter (OTC), refer to the UnitedHealthcare OTC 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.

For information about copayments for drugs that are covered by AHCCCS, please read the section about copayments.

Quality of Care concerns

Members/Health Care Decision Makers (HCDMs) can submit concerns that include but are not limited to:

- The inability to receive health care services,
- Concerns about the Quality of Care (QOC) received,
- Issues with health care provider,
- Issues with health plans, or
- Timely access to services.

Quality of concern issues may be submitted by calling Member Services at **1-800-348-4058**.

Member grievances (complaints) and appeals

Grievances

If you have questions or concerns about your medical care, you should talk about them with your PCP or the provider that is treating you first. If you are not happy with your doctor, UnitedHealthcare Community Plan, or any part of your health care, you can file a grievance (complaint) at any time. Your provider or representative can also file a grievance on your behalf with your written permission. We will help you in completing forms and taking other procedural steps related to filing a grievance. If you need help in filing a grievance over the phone or need language translation or interpreter services for a hearing or vision impairment you can call UnitedHealthcare Community Plan Member Services at **1-800-348-4058**. You can send your grievance in writing.

Send your written grievance to:

UnitedHealthcare Community Plan
Attn: Grievance Coordinator
1 East Washington Street
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.

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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;
- Does not allow members living in a rural area with only one health plan to obtain services outside the network; or
- Denies a member’s request to dispute a financial liability, including cost sharing, copayments, coinsurance, and other member financial liabilities.

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.

To file a grievance, an appeal, or to request a hearing with a RBHA regarding crisis services provided by the RBHA please call the RBHA directly:

Maricopa County served by Mercy Care: 1-800-631-1314 or 602-222-9444

Cochise, Graham, Greenlee, La Paz, Pima, Pinal, Santa Cruz and
Yuma Counties served by Arizona Complete Health – Complete Care Plan: 1-866-495-6735

Apache, Coconino, Gila, Mohave, Navajo and Yavapai Counties
served by Health Choice Arizona: 1-877-756-4090

Questions? Visit UHCCommunityPlan.com, 83
or call Member Services at **1-800-348-4058**, TTY 711.

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DD members:

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. We will provide assistance to you in completing forms and taking other procedural steps related to filing a grievance.

Contact Member Services at **1-800-348-4058**, TTY **711** to make your oral or written Grievance/Request for Investigation.

(continues on next page)

DD members:

Grievances/requests for investigation for a Serious Mental Illness (SMI) reason (continued from previous page)

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

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

Within 5 business days of receiving the Grievance/Request for Investigation UnitedHealthcare Community Plan will respond in writing to the person filing the Grievance/Request for Investigation confirming that the Grievance/Request for Investigation has been received.

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
801 E. Jefferson St., MD6200
Phoenix, AZ 85034

Or call 602-364-4575
or fax 602-364-4591

Deaf or hard-of-hearing individuals may call the Arizona Relay Service at 711 or 1-800-367-8939 for help contacting AHCCCS.

AHCCCS will send you a letter within 5 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.

Appeals

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. If you want to file a verbal appeal, call Member Services. Call **1-800-348-4058** for UnitedHealthcare Community Plan.

UnitedHealthcare Community Plan will provide assistance to you in completing forms and taking other procedural steps related to filing an appeal. If you need help filing an appeal, including the need for language translation or interpreter services for a hearing or vision impairment call Member Services at **1-800-348-4058**, TTY **711**. Appeal information is available in alternative formats. Your provider or family, health care decision maker or designated representative can also file an appeal on your behalf with your written permission. You or your family, health care decision maker or designated representative must file an appeal within 60 calendar days from the date of the Notice of Adverse Benefit Determination. 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 or DDD agree 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 an expedited review, 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.

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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.

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 Hearings

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 90 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.

DD members:

Appeals for SMI determination

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. Solari Crisis & Human Services, 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.

Solari Crisis & Human Services 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 Solari Crisis & Human Services at 1-855-832-2866 within 60 calendar days from the date on the Notice of Decision Letter.

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DD members:

Appeals for SMI determination (continued from previous page)

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 determination appeal?

If you file an appeal, you will get written notice that your appeal was received within 5 working days of Solari Crisis & Human Services' receipt. You will have an informal conference with Solari Crisis & Human Services 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.

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DD members:

What happens after I file an SMI determination appeal? (continued from previous page)

For an appeal that needs to be expedited, you will get written notice that your appeal was received within 1 working day of Solari Crisis & Human Services' 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. Solari Crisis & Human Services will assist you in filing a request for State Fair Hearing at the conclusion of Solari Crisis & Human Services' informal conference.

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

Will my services continue during the appeal process?

If you file an appeal, you will continue to get any services you were already getting unless a qualified clinician decides that reducing or terminating services is best for you, or you agree in writing to reducing or terminating services.

DD members:

SMI behavioral health appeals

Any person, age 18 or older, his or her guardian, or designated representative, may file an appeal related to services applied for or services the person is receiving. Matters of appeal are generally related to:

- Denial of services,
- Disagreement with the findings of an evaluation or assessment with any part of the Individual Service Plan, the Individual Treatment and Discharge Plan,
- Recommended services or actual services provided,
- Denial, reduction, suspension or termination of any service that is a covered service funded through Non-Title XIX/XXI funds. 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.
- Decision regarding fees or waivers
- Capacity to make decisions, need for guardianship or other protective services or need for special assistance

Appeals must be filed with UnitedHealthcare Community Plan and must be initiated no later than 60 days after the decision or action being appealed. Appeal forms are available through UnitedHealthcare Community Plan, AHCCCS, and at all provider sites. UnitedHealthcare Community Plan will attempt to resolve all appeals within 7 days through an informal process. If the issue cannot be resolved, the matter will be forwarded for further appeal. You may request an Administrative Review by AHCCCS. For SMI grievances/requests for investigation and appeals please include:

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

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DD members:

SMI behavioral health appeals (continued from previous page)

You may represent yourself, designate a representative, or use legal counsel. You may contact the State Protection and Advocacy System, the Arizona Center for Disability Law 1-800-922-1447 in Tucson and 1-800-927-2260 in Phoenix. You may also contact the Office of Human Rights at 602-364-4585, or 1-800-421-2124 for assistance. If your complaint relates to a licensed behavioral health agency, you may contact the Office of Behavioral Health Licensure, 150 N. 18th Avenue, Phoenix, Arizona 85007, 602-364-2595.

UnitedHealthcare Community Plan will provide assistance to you in completing forms and taking other procedural steps related to filing an appeal. If you need help filing an appeal, including the need for language translation or interpreter services for a hearing or vision impairment, contact Member Services at **1-800-348-4058**, TTY **711**. Appeal information is available in alternative formats. Your provider or family, health care decision maker or designated representative can also file an appeal on your behalf with your written permission. 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. Appeals can be submitted in writing or verbally to UnitedHealthcare. If you want to file a verbal appeal, call Member Services, **1-800-348-4058**, TTY **711**.

Send your written appeal to:

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

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DD members:

SMI behavioral health appeals (continued from previous page)

What happens after I file an SMI behavioral health appeal?

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

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

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

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

Will my services continue during the SMI behavioral health 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.

DD members:

If you have questions or concerns about your medical care, you should talk about them with your PCP or the provider that is treating you first.

If you are not happy about UnitedHealthcare Community Plan, your doctor, or any part of your health care, you can file a grievance (a complaint). Member Services will take your grievance, and then UnitedHealthcare Community Plan will look into the problem and decide what to do.

If you are not satisfied with an action UnitedHealthcare Community Plan has taken or if UnitedHealthcare Community Plan has denied a service that you think you should receive, you may file a formal complaint (appeal) with UnitedHealthcare Community Plan. You can call Member Services or write to the address listed on page 85.

Member rights

You have the right to:

- File a complaint or an appeal about your health plan or the care it provides
- Request information about the structure and operation of the health plan and its subcontractors
- Request information on whether or not UnitedHealthcare Community Plan has Physician Incentive Plans (PIP) that affect the use of referral services, the right to know the types of compensation arrangements the Contractor uses, the right to know whether stop-loss insurance is required and the right to a summary of member survey results, in accordance with PIP regulation
- Be treated fairly and receive covered benefits and services regardless of race, ethnicity, color, gender, religion, age, national origin, ability to speak English, ability to pay, marital status, sexual preference, genetic information, behavioral health condition, intellectual or physical disability
- Have services given in a way that respects your culture, language, background, and abilities
- Receive interpreter services at no charge
- Get this information in a language or format that you understand, including sign language or Braille
- Privacy during medical visits, appointments, and treatments
- Privacy and protection of your health information
- Change your doctor to another doctor that is contracted with UnitedHealthcare Community Plan

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- Have freedom of choice to see any in-network provider. Members cannot obtain services from a provider who is not contracted with UnitedHealthcare Community Plan (unless prior approved by the health plan). If you have other insurance, you can see a non-contracted provider. If you are unsure, call UnitedHealthcare Community Plan Member Services.
- Know the professional background of any person involved in your care
- Know the name of your doctor
- Know that at times the health plan may coordinate care with schools and state agencies as allowed
- Talk to your doctor about your health care and how to get covered services. Call Member Services if you have questions that your doctor did not answer.
- Develop contingency planning with their provider agency to decide their preferences when a caregiver is late or is a no-show
- 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.
- Receive notification when assigned PCP or frequently used provider leaves the network
- Get information on available treatments and treatment options regardless of cost or benefit coverage and the right to refuse treatment appropriate to your condition in language that you understand
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand the information
- Get information on Advance Directives
- Access your medical records or child's medical records annually at no cost to you as allowed by law and receive a response within 30 days to your request for a copy of the medical records. The response may be the copy of the medical record or a written denial that includes the basis for the denial and information about how to seek review of the denial in accordance with 45 CFR Part 164.
- Member has the right to request their medical records be amended or corrected as allowed by law
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation
- Receive information about your benefits and health plan, practitioners and providers, and member rights and responsibilities
- Be treated with respect and dignity by UnitedHealthcare Community Plan staff and health care providers
- Receive information on beneficiary and plan information

- Be involved in decisions about your health care, or have a representative facilitate care or help make decisions if you are not able to do so
- Refuse care or refuse care from certain doctors
- Know the languages spoken by each contracted UnitedHealthcare Community Plan doctor
- Receive emergency care at any hospital or other setting without approval from your doctor or UnitedHealthcare Community Plan
- Get information on how to get mental health care, substance abuse services, or a referral for specialty services not provided by your PCP
- Know how UnitedHealthcare Community Plan evaluates new technology and decides to cover new treatments
- Know if you need insurance for very large claims (stop-loss insurance)
- Know how UnitedHealthcare Community Plan compensates doctors
- Receive a summary of member survey results
- Request information about grievances, appeals and requests for hearings
- Request information about getting services outside UnitedHealthcare Community Plan's contracted service area
- Request the criteria used to make decisions about your care
- Make recommendations regarding the organization's member rights and responsibility policy

Electronic Visit Verification (EVV)

EVV is a computer-based system that electronically verifies the occurrence of authorized service visits by electronically documenting the exact time a service delivery visit begins and ends, the individuals receiving and providing a service, and the type of service performed.

We are using EVV to make sure that you get the services that you need when you need them. To receive Direct Care Services you must participate in EVV. We are designing the system to support how you manage your care including scheduling your services and monitoring your service hours. You will have the option to choose which device is used to verify that you have received a service. These services may be provided by different provider agencies, including:

- Daily living skills
- Home health
- Respite care
- Therapy

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The EVV system electronically verifies the:

- Service type
- Member
- Date of service
- Service location
- Provider
- Service times (start and end)

What stays the same	What will change
Members have choice of provider	Paper time sheet will be eliminated
Availability of services	EVV device will be used to verify service delivery
Members have choice of individual direct care worker	How member, health care decision maker/ designated representative signature is collected
How services are provided	Verification will be required by member, health care decision maker/designated representative at the end of every visit/shift
Where services are provided	

EVV is designed for you:

- EVV works wherever services take place, whether at home or in the community
- EVV supports case management, including the scheduling and monitoring of service hours
- Members have the option to choose what device they want to use to verify that service has been received
- Members can decide how quickly a replacement caregiver will be needed if the scheduled caregiver is late or no-shows
- For questions, contact Member Services at **1-800-348-4058**, TTY **711**
- For additional information visit: <https://azahcccs.gov/EVV>

Fraud, waste, and abuse

Fraud

UnitedHealthcare Community Plan provides services to people who are in need and qualify for services. It is important to make sure that our members and providers follow the rules for getting and billing for covered services. If the rules aren't followed, a member or provider might be committing fraud. Fraud is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable State or Federal law, as defined in 42 CFR 455.2. Report anything you see that doesn't look right. This includes:

- Using someone else's ID card or allowing someone to use yours
- Giving a wrong address in order to qualify for AHCCCS
- A doctor or facility billing you for covered services
- A doctor giving you services you don't need
- A provider offering inappropriate services

Waste

Over-utilization or inappropriate utilization of services, misuse of resources, or practices that result in unnecessary costs to the Medicaid Program.

Abuse

Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the AHCCCS program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the AHCCCS Program. 42 CFR 455.2.

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.

Reporting fraud, waste, and abuse

Fraud, waste and abuse are serious offenses. There can be penalties under the law. You can report fraud, waste or abuse by calling Member Services. You can also call AHCCCS at 1-888-487-6686 or 602-417-4193. Or, go to their website, azahcccs.gov. You do not have to give your name. You will not get in trouble for reporting fraud, waste or abuse.

A provider may commit fraud, waste 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, waste 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 Advocates/Liaisons/Coordinators

UnitedHealthcare Community Plan supports our members by having member liaisons and the 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 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 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).

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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 requests, 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.

Employment/Vocational Administrator — The employment/vocational administrator is dedicated to employment and rehabilitation related activities. The administrator develops vocational services to assist members in achieving their rehabilitation/employment goals and ensures that behavioral health providers are engaging in employment discussions with members. The administrator is responsible for managing and overseeing employment support programs for providers with the goal of increasing employment outcomes for members.

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.

DD members:

Behavioral Health Coordinator — A behavioral health professional who serves as a primary point of contact to provide plan-level leadership in working with behavioral health providers and other member-serving agencies. The role includes addressing barriers to crisis and other behavioral health care concerns raised by the DD member, family member(s), and parent(s)/guardian(s). The Behavioral Health Coordinator works collaboratively with network managers to reduce out-of-state placements and provides referral assistance.

Children Services Liaison — A designated point of contact for addressing concerns related to the delivery of and access to behavioral health services for our DD members. This role includes accepting and responding to inquiries from the out-of-home caregiver, Adoptive Parent(s), or providers to address barriers, including non-responsive crisis providers.

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

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Veterans Liaison – The Veterans Liaison is experienced in working with Veterans and family members of veterans, advocates and providers. The Liaison provides education and support to our veterans to help them through the health system to ensure their 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 Liaison at milvet_advocate@uhc.com.

General member rights under the Home and Community Based Services (HCBS)

The purpose of the HCBS Rules is to ensure individuals receiving HCBS are integrated into their communities and have full access to the benefits of community living.

These new requirements, from the Centers for Medicare and Medicaid Services (CMS), impact individuals receiving services in residential and non-residential settings such as assisted living facilities, group homes, adult day health, day treatment and training, center-based employment programs, etc.

Community resources

Ability 360

Ability 360 offers and promotes programs designed to empower people with disabilities to take personal responsibility so that they may achieve or continue independent lifestyles within the community.

If you live outside of Maricopa county call the 800 number below.

Main Office

5025 East Washington Street, Suite 200
Phoenix, AZ 85034

1-602-256-2245

1-800-280-2245

<http://ability360.org/>

AZ Disability Benefits 101 (AZ DB101)

Is an online tool to help Social Security beneficiaries make informed decisions about going to work.
www.az.db101.org

Questions? Visit UHCCommunityPlan.com, 101
or call Member Services at **1-800-348-4058**, TTY 711.

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ABLE National Resource Center

ABLE accounts are tax-advantaged savings accounts for individuals with disabilities and their families.

Phone: **202-683-6094**

<http://www.ablenrc.org/state-review/arizona>

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>

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 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**

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

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Arizona Rehabilitation Services Administration (RSA)

RSA oversees several programs which are designed to assist eligible individuals who have disabilities to achieve employment outcomes and enhanced independence by offering comprehensive services and supports.

To learn more, call **1-800-563-1221** or go to
<https://des.az.gov/rsa-contact-information>
https://www.azdes.gov/rehabilitation_services/

Arizona@Work

A statewide workforce development network that provides jobseekers with services and resources to pursue employment opportunities.

<http://www.arizonaatwork.com/>

Area Agency on Aging

The goal of an Area Agency on Aging (AAA) 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 programs offered are designed to enhance the quality of life of residents and caregivers. AAA advocate, plan, coordinate, develop and deliver numerous programs and services.

The AAA provides education about Medicare and the different Medicare Plan options. In addition, they have a Long Term Care Ombudsman Program. 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. If you have a complaint, concern or would like more information, contact your local AAA. The AAAs are listed below by county:

Maricopa County

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

Phone: **602-264-4357**

Toll-Free: **1-888-783-7500**

Coconino, Yavapai, Apache, and Navajo Counties

<http://nacog.org/>

Phone: **928-774-1895**

Toll-Free: **1-877-521-3500**

La Paz, Mohave, and

Yuma Counties

<http://www.wacog.com/>

Phone: **1-800-782-1886**

Mohave County

Phone: **928-753-6247**

Gila and Pinal Counties

Phone: **520-836-2758**

Toll-Free: **1-800-293-9393**

Pima County

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

Phone: **520-790-7262**

Questions? Visit UHCCommunityPlan.com, 103
or call Member Services at **1-800-348-4058**, TTY 711.

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Arizona 211

This website helps you find resources for child care, jobs, health care, food, 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's Aging and Disability Resource Center (ADRC)

ADRC was created to help Arizona seniors, people with disabilities, caregivers and family members locate resources and services that meet their needs.

Phone: **602-542-4446** or toll-free **1-888-737-7494**,
hearing impaired (TTY/TDD) **1-866-602-1982**

www.azlinks.gov

Arizona Alzheimer's Association

1-800-272-3900 for the Alzheimer's Association 24-hour helpline.

<http://www.alz.org/dsw>

Arizona Association of Community Health Centers

Is a membership of non-profit public primary care centers. For more information, visit the website at <http://www.aachc.org/>, call **602-253-0090** or send an email to info@aachc.org.

Arizona Center for Disability Law

Arizona Center for Disability Law is a non-profit law firm that assists Arizonans with disabilities to promote and protect their legal rights to independence, justice, and equality.

Phone: **1-800-927-2260** (Phoenix) or **1-800-922-1447** (Tucson)

azdisabilitylaw.org

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Arizona Caregiver Coalition

Their mission is to improve the quality of life for family caregivers across Arizona through Collaborative Partnerships, Advocacy, Resources, and Respite Support.

<https://azcaregiver.org>

Caregiver Toll-Free Resource Line: **1-888-737-7494**

or by email: info@azcaregiver.org

Arizona Coalition Against Sexual and Domestic Violence

Phone: **1-800-782-6400**

acesdv.org

Arizona Department of Health Services – Bureau of Women and Children’s Health

Office for Children with Special Health Care Needs (OCSHCN) – The Office for Children with Special Health Care Needs (OCSHCN) continues working to improve systems of care; provide information and referral to families who would like assistance in finding the services available to their child; provide training to families and professionals on best practices related to medical home, cultural competence, transition to adulthood and family and youth involvement; and support telemedicine to provide services in remote areas of the state. You may contact OCSHCN by calling **1-800-232-1676** or sending an email to OCSHCN@azdhs.gov. Their website is <https://www.azdhs.gov/prevention/womens-childrens-health/ocshcn/index.php>.

Arizona Department of Health Services, Health Systems Development

Offers programs and services to improve access to primary health care for underserved and vulnerable populations. For more information, visit the website at <https://www.azdhs.gov/audiences/index.php> or call **602-542-1025**.

Arizona Rehabilitation Services Administration (RSA)

Arizona Rehabilitation Services Administration (RSA) oversees several programs which are designed to assist eligible individuals who have disabilities to achieve employment outcomes and enhanced independence by offering comprehensive services and supports.

To learn more, call **1-800-563-1221** or go to <https://des.az.gov/rsa-contact-information>.
https://www.azdes.gov/rehabilitation_services/

Questions? Visit UHCCommunityPlan.com, 105
or call Member Services at **1-800-348-4058**, TTY 711.

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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 **1-800-348-4058**, or visit the website UHCCCommunityPlan.com.

AZ Suicide Prevention Coalition

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

<http://www.azspc.org>

Centers for Independent Living (CILs)

These are typically non-residential, private, non-profit, consumer-controlled, community-based organizations providing services and advocacy by and for persons with all types of disabilities. Their goal is to assist individuals with disabilities to achieve their maximum potential within their families and communities. Independent Living Centers also serve as a strong advocacy voice on a wide range of issues. They work to assure physical and programmatic access to housing, employment, transportation, communities, recreational facilities, and health and social services.

Ability 360

5025 E. Washington St., Suite 200
Phoenix, AZ 85034
Phone: **602-256-2245**,
Toll-Free: **1-800-280-2245**
<http://ability360.org/>

DIRECT Center for Independence

1001 N. Alvernon Way
Tucson, AZ 85711
Phone: **520-624-6452**
<http://directilc.org/>

New Horizons Disability Empowerment Center

9400 E. Valley Road
Prescott Valley, AZ 86314
Phone: **928-772-1266**
www.nhdec.org

ASSIST! to Independence

P.O. Box 4133
Tuba City, AZ 86045
Phone: **928-283-6261**, Toll-Free: **1-888-848-1449**
<http://www.assistti.org/>

S.M.I.L.E. (Services Maximizing Independent Living and Empowerment)

1929 S. Arizona Ave., Suite 11
Yuma, AZ 85364
Phone: **928-329-6681**
www.smile-az.org

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

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Dump the Drugs AZ

Prescriptions drug drop-off locations:

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

Family Involvement Center

Family Involvement Center is a not-for-profit, family-directed run organization that was founded in 2001. The majority of employees and Board of Directors have personal life experience raising children with emotional, behavioral, and/or mental health challenges. Services include parent training, resources and support.

Family Involvement Center
5333 N 7th Street, Suite A-100
Phoenix, AZ 85014

Parent Assistance: **602-288-0155**
1-877-568-8468 Toll-Free
Administration: **602-412-4095**
www.familyinvolvementcenter.org

Family planning services and HIV testing

Please contact your primary health care provider for information about family planning and HIV/STI testing. For additional information about family planning services and HIV testing, call the ADHS Bureau of Women's and Children's Health Hot Line at **1-800-833-4642** or visit the website at www.azdhs.gov/phs/owch/index.htm. Family planning services and HIV/STI testing are available at the Arizona Family Partnership **602-258-5777** or **1-888-272-5652** or visit the website at www.arizonafamilyhealth.org. Planned Parenthood also offers testing and services. Call **1-800-230-7526**. You may also get additional information from your AHCCCS or ALTCS health plan.

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 is a program that provides 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 locator at <http://eclkc.ohs.acf.hhs.gov/hslc/HeadStartoffices>.

Questions? Visit UHCCommunityPlan.com, 107
or call Member Services at **1-800-348-4058**, TTY 711.

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Health-e-Arizona Plus

Get information about AHCCCS coverage and apply online at www.healtharizonaplus.gov or call **1-855-432-7587**, 7:00 a.m.–6:00 p.m., Monday–Friday.

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

- AHCCCS
- Part D, which is the Medicare prescription drug benefit
- KidsCare
- Behavioral Health
- Medicare
- Other medical insurance

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

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 at <http://www.azdhs.gov/prevention/tobacco-chronic-disease/tobacco-free-az/index.php>.

Or contact ASHLine Arizona Smokers' Helpline: **1-800-55-66-222**.

For Prescription to Quit, ASHLine will call you back within three days. If you're ready to QUIT NOW do not wait, call now **1-800-55-66-222**. www.ashline.org

Home visiting programs

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>. Outside Maricopa County, go to <https://strongfamiliesaz.com/programs/> to find information on Home Visiting programs available in your area.

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

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Information and referral services

The Children's Information Center Hotline can help you find resources in your community. The statewide toll-free number is **1-800-232-1676**. For people with hearing loss or impairment, there is a State Telecommunication Device (TTY/TDD) at **1-800-367-8939**. The hotline operates 8:00 a.m.–5:00 p.m., Monday–Friday.

Legal aid

www.azlawhelp.org/legalaidlisting.cfm

Low-income housing

For information on low-income housing and shelter:

<https://211arizona.org/>

Income-based housing:

- Subsidized apartment search:
<https://resources.hud.gov/> Subsidized apartment search
- Public Housing Authorities:
https://www.hud.gov/program_offices/public_indian_housing/pha/contacts
- Housing Choice Vouchers (Section 8):
https://www.hud.gov/topics/housing_choice_voucher_program_section_8
- Section 202 Supportive Housing for the Elderly:
https://www.hud.gov/program_offices/housing/mfh/grants/section202ptl
- Section 811 Supportive Housing for Persons with Disabilities:
https://www.hud.gov/program_offices/housing/mfh/grants/section811ptl

Eviction prevention resources:

- Emergency Rental Assistance:
<https://www.consumerfinance.gov/coronavirus/mortgage-and-housing-assistance/renter-protections/find-help-with-rent-and-utilities/>
- HUD Approved Housing Counseling Agencies:
<https://apps.hud.gov/offices/hsg/sfh/hcc/hcs.cfm?&webListAction=search&searchstate=AZ>
- Department of Housing & Urban Development subsidized apartment search tool:
<https://resources.hud.gov/>

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Mental Health America of Arizona (MHA AZ)

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

Contact Mental Health America of Arizona weekdays by calling **602-576-4828**, outside Maricopa County, **1-800-MHA-9277**.

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.

602-244-8166

<http://www.namiarizona.org>

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

www.bannerhealth.com/services/poison-drug-information/opioid-assistance

AHCCCS Opioid Service Locator:

<https://opioidservicelocator.azahcccs.gov/>

Pilot Parents of Southern Arizona

Provides services for children and adults with developmental disabilities and their families.

Services include parent training and parent leadership development. For more information call

1-877-365-7220 or **520-324-3150**, or email ppsa@pilotparents.org.

www.pilotparents.org

Poison Control

Poison Control is available 24 hours a day to provide no cost, expert and confidential guidance in a poison emergency. If the individual collapses, has a seizure, has trouble breathing, or can't be awakened: **Call 911 immediately.**

1-800-222-1222

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

Raising Special Kids – Arizona's family-to-family health information center

Raising Special Kids is a non-profit organization of families helping families of children with disabilities and special health needs in Arizona. They provide information, training and materials to help families understand and navigate systems of care. Parents are supported in their leadership development as they learn to advocate for their children. Raising Special Kids promotes opportunities for improving communication between parents, youth with disabilities, educators and health professionals. All programs and services are provided to families at no cost.

Raising Special Kids

5025 East Washington Street, Suite 204

Phoenix, AZ 85034

1-800-237-3007 Toll-Free

602-242-4366

www.raisingpecialkids.org

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Residential options

Public Housing (HUD):

<https://portal.hud.gov/hudportal/HUD?src=/states/arizona/renting/haweb/sites>

Privately Owned Subsidized Housing Program:

<http://www.hud.gov/apps/section8>

Housing Choice Voucher Program:

<https://portal.hud.gov/hudportal/HUD?src=/states/arizona/renting/haweb/sites>

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.

602-542-1025

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

Vocational rehabilitation

The Vocational Rehabilitation program provides a variety of services to persons with disabilities, with the ultimate goal to prepare for, enter into, or retain employment.

1-800-563-1221

<https://des.az.gov/services/employment/rehabilitation-services/vocational-rehabilitation-vr>

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 for more information.

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.

COVID-19 protects against the COVID-19 virus.

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.

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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	18–64 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
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

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Type of service	18–64 years old	65 years old and over
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.

Decisions about your health care (Advance Directives)

You have rights and responsibilities as a member of UnitedHealthcare Community Plan. One is the right to decide about different options for your health care and treatment. To make sure the decisions you make about your care are followed, you should write them down. This document is called an Advance Directive. Advance Directives are not difficult to write. It can be short sentences. It tells health care professionals what you want done if you become very ill and can't tell them yourself. If you are not able to express your decisions, a court may appoint a guardian to make decisions for you.

An Advance Directive is a written statement about how you want your health decisions made. Under Arizona law there are four common types. These are:

1. A health care power of attorney
2. A living will
3. Pre-hospital medical care directive
4. Mental health care power of attorney

Health care power of attorney

Someone to whom you have given the authority to make health care decisions for you if you cannot make them (usually a close friend, relative or spouse). This person is called an “agent.”

Living will

A document where you write out the specific type of health care treatment(s) you do or do not want if you are not able to express your decisions to your doctor. It can also tell your doctor whether or not to make special efforts to save your life if you are seriously ill.

Pre-hospital medical care directive

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.

Mental health care power of attorney

A document used use if you want to appoint a person to make future mental health care decisions for you if you become unable to make decisions for yourself.

Give your doctor a copy of your Advance Directives. Keep a copy for yourself. You may change these directions anytime. If you make changes, be sure everyone has a new copy.

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UnitedHealthcare Community Plan cannot help you with these directions. The following groups can give you information and help you write directions about your health care decisions:

In Tucson:

Southern Arizona Legal Aid

Phone: 520-623-9465

Fax: 520-620-0443

www.sazlegalaid.org

Statewide:

Community Legal Services, Inc.

305 South 2nd Avenue

P.O. Box 21538

Phoenix, AZ 85036-1538

Phone: 1-800-852-9075

Arizona Attorney General:

www.azag.gov/seniors/life-care-planning

The Arizona Advance Directive Registry is a free registry you can use to electronically store and access your medical directives. Their secure and confidential program grants peace of mind to registrants and their families, and easy access to all health care providers. For more information visit: Arizona Health Information Exchange at: <https://healthcurrent.org/azhdr>.

The Advance Directive Registry has been moved from the Arizona Secretary of State's Office to Health Current, Arizona's Health Information Exchange site.

DD members:

Your DDD Support Coordinator can assist you in developing an Advance Directive. Your DDD Support Coordinator can be reached by calling 1-844-770-9500, Option 1.

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.

Health Insurance: Coverage of costs for health care services.

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or call Member Services at **1-800-348-4058**, TTY **711**.

AHCCCS Complete Care and Developmental Disabilities Member Handbook

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.

AHCCCS Complete Care and Developmental Disabilities Member Handbook

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

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

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

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

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

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Maternity Care Provider — The following are provider types who may provide maternity care when it is within their training and scope of practice:

1. Arizona licensed allopathic and/or osteopathic physicians who are obstetricians or general practice/family practice providers.
2. Physician Assistant(s).
3. Nurse Practitioners.
4. Certified Nurse Midwives, and
5. Licensed Midwives.

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

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

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.

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.
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 **1-800-348-4058**, 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 **1-800-348-4058**, 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 **1-800-348-4058**, TTY **711**, 8 a.m.–5 p.m., Monday–Friday.

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Questions? Visit UHCCommunityPlan.com, 123
or call Member Services at **1-800-348-4058**, TTY **711**.

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DD members:

Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI and VII) and the Americans with Disabilities Act of 1990 (ADA) Section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975, UnitedHealthcare Community Plan prohibits discrimination in admissions, programs, services, activities or employment based on race, color, religion, sex, national origin, age, and disability. UnitedHealthcare Community Plan must make a reasonable accommodation to allow a person with a disability to take part in a program, service, or activity.

Auxiliary aids and services are available upon request to individuals with disabilities such as obtaining an audio reading of plan materials for the visually impaired. For example, this means that if necessary, UnitedHealthcare Community Plan must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. UnitedHealthcare Community Plan also offers language interpretation services in over 240 languages.

It also means that UnitedHealthcare Community Plan will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible.

To request this document in alternative format or for further information about this policy please contact: UnitedHealthcare Community Plan Member Services at **1-800-348-4058**. Para obtener este documento en otro formato u obtener información adicional sobre esta política, comuníquese con UnitedHealthcare Community Plan.

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, 2022

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 e-mail. 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 collect, use, and share your information

We collect, use and share your HI with:

- You or your legal representative.
- Government agencies.

We have the right to collect, 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 collect, use, and share your HI to process premium payments and claims. This may include coordinating benefits.
- **For Treatment or Managing Care.** We may collect, use, and 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, 125
or call Member Services at **1-800-348-4058**, TTY 711.

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- **For Underwriting Purposes.** We may collect, use, and share your HI to make underwriting decisions. We will not use your genetic HI for underwriting purposes.
- **For Reminders on Benefits or Care.** We may collect, use and share your HI to send you appointment reminders and information about your health benefits.
- **For Communications to You.** We may use the phone number or email you gave us to contact you about your benefits, healthcare or payments.

We may collect, use, and 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.

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- **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.

Questions? Visit UHCCommunityPlan.com, 127
or call Member Services at **1-800-348-4058**, TTY 711.

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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).
- **To ask that we correct or amend** your HI. Depending on where you live, you can also ask us to delete your HI. If we can't, we will tell you. If we can't, you can write us, noting why you disagree and send us the correct information.

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/RTT **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, Incorporated; 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 Community Plan of Georgia, Inc.; UnitedHealthcare Insurance Company; UnitedHealthcare Insurance Company of America; 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.; and UnitedHealthcare Plan of the River Valley, Inc. This list of health plans is complete as of the effective date of this notice. For a current list of health plans subject to this notice go to <https://www.uhc.com/privacy/entities-fn-v2>.

128 **Questions?** Visit UHCCCommunityPlan.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, 2022

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.

AHCCCS Complete Care and Developmental Disabilities Member Handbook

Questions about this notice

Please **call the toll-free member phone number on health plan ID card** or contact the UnitedHealth Group Customer Call Center at **1-866-633-2446**, or TTY/RTT **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 Corporation.; Dental Benefit Providers, Inc.; Ear Professional International Corporation; gethealthinsurance.com Agency, Inc. Genoa Healthcare, LLC; Golden Outlook, Inc.; Level2 Health IPA, LLC; Level2 Health Management, LLC; Life Print Health, Inc.; Managed Physical Network, Inc.; Optum Care Networks, Inc.; Optum Global Solutions (India) Private Limited; Optum Health Care Solutions, Inc.; OptumHealth Holdings, LLC; Optum Labs, LLC; Optum Networks of New Jersey, Inc.; Optum Women’s and Children’s Health, LLC; OrthoNet, LLC; OrthoNet of the South, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; Physician Alliance of the Rockies, LLC; POMCO Network, Inc.; POMCO, Inc.; Real Appeal, Inc.; Sanvello Health, Inc.; Spectera, Inc.; Three Rivers Holdings, Inc.; UHIC Holdings, Inc.; UMR, Inc.; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; UnitedHealthcare, Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Service LLC; Urgent Care MSO, LLC; USHEALTH Administrators, LLC; and USHEALTH Group, Inc.; and Vivify Health, 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 complete as of the effective date of this notice. For a current list of health plans subject to this notice go to <https://www.uhc.com/privacy/entities-fn-v2>.



We're here for you

Remember, we're always ready to answer any questions you may have. Just call Member Services at **1-800-348-4058**. You can also visit our website at UHCCommunityPlan.com.

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

UHCCommunityPlan.com

1-800-348-4058

United
Healthcare
Community Plan

Questions? Visit UHCCommunityPlan.com, 131
or call Member Services at **1-800-348-4058**, TTY 711.

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