New Mexico

Welcome to the community

Turquoise Care Member Handbook
Community Health Plan of NM

UnitedHealthcare Community Plan of NM is a product of UnitedHealthcare Insurance Company

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Welcome

Welcome to UnitedHealthcare Community Plan

Please take a few minutes to review this Member Handbook. We're ready to answer any questions you may have. Just call Member Services at **1-877-236-0826**, TTY **711**, 8:00 a.m.–5:00 p.m. MT, Monday–Friday. You can also visit our website at **myuhc.com/communityplan/nm**.

Getting started

We want you to get the most from your health plan right away. Start with these three easy steps:

1. Call your Primary Care Provider (PCP) and schedule a checkup

Regular checkups are important for good health. Your PCP's phone number should be listed on the member ID card that you recently received in the mail. If you don't know your PCP's number, or if you'd like help scheduling a checkup, call Member Services at **1-877-236-0826**, TTY **711**. We're here to help.

2. Take your Health Assessment

This is a short and easy way to get a big picture of your current lifestyle and health. This helps us match you with the benefits and services available to you. You will soon receive a welcome phone call from us. We also will help you complete a survey about your health. This short survey helps us understand your needs so that we can serve you better. To complete your Health Assessment, call Member Services at **1-877-236-0826**, TTY **711**.

3. Get to know your health plan

Start with the Health Plan Highlights section on page 14 for a quick overview of your new plan. And be sure to keep this booklet handy, for future reference.

Such services are funded in part with the State of New Mexico.

Welcome to UnitedHealthcare Community Plan.

Thank you for choosing UnitedHealthcare as your Turquoise Care health plan. Our personal approach is designed to help you achieve better health and well-being. We want you to feel in control of your health care and get all of the benefits and services you may need. It is important that you take your Health Assessment. This is a short and easy way to get a big picture of your current lifestyle and health. This helps us match you with the benefits and services available to you. It allows us to better understand your needs so that we can serve you better. You will soon receive a welcome phone call from us and at that time we will help you complete your Health Assessment. You can also call us to complete your Health Assessment. Please call Member Services at **1-877-236-0826**, TTY **711**, between 8:00 a.m. and 5:00 p.m. MST, Monday through Friday.

Enclosed is a Member Handbook with some important information for you. The Member Handbook explains how to use your health plan. It lets you know how Turquoise Care works. It describes your member ID card, and your benefits, including your UnitedHealthcare Value Added Benefits. Please read the Member Handbook and keep it close by to check information you may need to know in the future. You should have already received your member ID card in a separate mailing.

The Provider Directory is available online and lets you know which doctors, hospitals, and other providers are in your area. You can also use the online Doctor Lookup tool to find a doctor in your area. Please visit our website at **myuhc.com/communityplan/nm**.

Scroll down the page and under "Lookup Tools" you can click on Doctor Lookup to find a doctor in your area or Download Directories to view the Provider Directory. If you do not have access to the Internet, or would like a paper Provider Directory, you can contact Member Services at **1-877-236-0826**, TTY **711**, between 8:00 a.m. and 5:00 p.m. MST, Monday through Friday.

Remember, we're always ready to answer any questions you may have. Just call Member Services at **1-877-236-0826**, TTY **711**. You can also visit our website at **myuhc.com/communityplan/nm**.

Sincerely,
Andrew Peterson, CEO
UnitedHealthcare Community Plan

Office address:
609 Broadway Boulevard NE, Suite 125
Albuquerque, NM 87102

Key words used in this handbook

As you read this handbook, you may see some new words. Here is what we mean when we use them.

Adult Care Home: A licensed residential care setting with seven or more beds for elderly or disabled people who need some additional supports. These homes offer supervision and personal care appropriate to the person's age and disability.

Adult Preventive Care: Care consisting of wellness checkups, patient counseling and regular screenings to prevent adult illness, disease and other health-related issues.

Advance Directive: A written set of directions about how medical or mental health treatment decisions are to be made if you lose the ability to make them for yourself.

Adverse Benefit Determination: A decision your health plan can make to deny, reduce, stop or limit your health care services.

Appeal: If the health plan makes a decision you do not agree with, you can ask them to review it. This is called an "appeal." Ask for an **appeal** when you do not agree with your health care service being denied, reduced, stopped or limited. When you ask your health plan for an appeal, you will get a new decision within 30 days. This decision is called a "resolution." **Appeals and grievances are different.**

Behavioral Health Care: Mental health (emotional, psychological and social well-being) and substance use (alcohol and drugs) disorder treatment and recovery services.

Benefits: A set of health care services covered by your health plan.

Care Coordination: Care Coordination involves deliberately organizing Member care activities and sharing information among all participants concerned with a member's care to achieve safer and more effective care. This means that the member's needs and preferences are known ahead of the time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate and effective care to the Member.

Care Management: A service where a care manager can help you meet your health goals by coordinating your medical, social and behavioral health services and helping you find access to resources like transportation, healthy food and safe housing.

Care Manager: A health professional who can help you meet your health goals by coordinating your medical, social and behavioral health services and helping you find access to sources like transportation, healthy food and safe housing.

Children's Screening Services: A medical examination to monitor how a child is developing. Screening services can help identify concerns and problems early. The screenings assess social/emotional behavior, vision and hearing, motor skills and coordination, cognitive abilities, language and speech.

Copayment (Copay): An amount you pay when you get certain health care services or a prescription.

Covered Services: Health care services that are provided by your health plan.

Critical Incident: An occurrence, that involves a recipient and requires the program to respond in a manner that is not a part of the program's ordinary daily routine including but not limited to: abuse, neglect, exploitation, death, environmental hazard etc.

Durable Medical Equipment: Certain items (like a walker or a wheelchair) your doctor can order for you to use at home if you have an illness or an injury.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT): Means the federally required Early and Periodic Screening, Diagnostic and Treatment program, as defined in Section 1905(r) of the Social Security Act and 42 C.F.R. § 441, Subpart B for members under the age of twenty-one (21). It includes comprehensive periodic and inter-periodic screening and diagnostic services to determine physical and behavioral health needs as well as the provision of all Medically Necessary Services listed in Section 1902(a) of the Social Security Act even if the service is not available under the State's Medicaid State Plan.

Early Intervention: Services and support available to babies and young children with developmental delays and disabilities and their families. Services may include speech and physical therapy and other types of services.

Emergency Department Care: Care you receive in a hospital if you are experiencing an emergency medical condition.

Emergency Medical Condition: A situation in which your life could be threatened, or you could be hurt permanently if you do not get care right away.

Emergency Medical Transportation: Ambulance transportation to the nearest hospital or medical facility for an emergency medical condition.

Emergency Room (ER) or Emergency Department (ED): Means a portion of the hospital where emergency diagnosis and treatment of illness or injury is provided.

Emergency Services: Services you receive to treat your emergency medical condition.

Enteral Formula: Balanced nutrition especially designed for the tube-feeding of children.

Excluded Services: Means services that are not Covered Services as defined in this Agreement.

Fair Hearing: See "State Fair Hearing."

Grievance: Dissatisfaction about your health plan, provide, care or services. Contact your health plan and tell them you have a "grievance" about your services. **Grievances and appeals are different.**

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

Health Insurance: A type of insurance coverage that pays for your health and medical costs. Your Medicaid coverage is a type of insurance.

Health Plan (or Plan): The Company providing you with health care services.

Home Health Care: Certain services you receive outside a hospital or a nursing home to help with daily activities of life, like home health aide services, skilled nursing or physical therapy services.

Hospice Services: Special services for patients and their families during the final stages of terminal illness and after death. Hospice services include certain physical, psychological, social and spiritual services that support terminally ill individuals and their families or caregivers.

Hospital Outpatient Care: Services you receive from a hospital or other medical setting that do not require hospitalization.

Hospitalization: Admission to a hospital for treatment that lasts more than 24 hours.

In-Network Provider (Participating Provider): A provider that is in your health plan's provider network.

Institution: A Health care facility or setting that may provide physical and/or behavioral supports. Some examples include, but are not limited to, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID), Skilled Nursing Facility (SNF) and Adult Care Home (ACH).

Legal Guardian or Legally Responsible Person: A person appointed by a court of law to make decisions for an individual who is unable to make decisions on their own behalf (most often a family member or friend unless there is no one available, in which case a public employee is appointed).

Long-Term Services and Supports (LTSS): Means services and supports provided to members of all ages with functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of a member to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider-owned or controlled residential setting, a Nursing Facility, or other institutional setting.

Managed Care Organization (MCO): Means an entity that meets the requirements of 42 CFR § 438.2 and participates in Turquoise Care under contract with HCA to assist the State in meeting the requirements established under NMSA 1978, § 27-2-12.

Medicaid: Medicaid is a health coverage program. The program helps some families or individuals who have low income or serious medical problems. It is paid with federal, state and county dollars and covers many physical health, behavioral health, and Long-Term Care services.

Medically Necessary: Medical services, treatments or supplies that are needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Member: A person enrolled in and covered by a health plan.

Network (or Provider Network): A group of doctors, hospitals, pharmacies and other health professionals who have a contract with your health plan to provide health care services for members.

Non-Covered Services: Health care services that are not covered by your health plan.

Non-Emergency Medical Transportation (NEMT): Transportation your plan can arrange to help you get to and from your appointments, including personal vehicles, taxis, vans, mini-buses, mountain area transports and public transportation.

Ongoing Course of Treatment: When a member, in the absence of continued services, reflected in a treatment or service plan or as otherwise clinically indicated, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization.

Ongoing Special Condition: A condition that is serious enough to require treatment to avoid possible death or permanent harm. A chronic illness or condition that is life-threatening, degenerative, or disabling and requires treatment over an extended period. This definition also includes pregnancy in its second or third trimester, scheduled surgeries, organ transplants, scheduled inpatient care or being terminally ill.

Out-of-Network Provider (or Non-Participating Provider): A provider that is not in your health plan's provider network.

Palliative Care: Specialized care for a patient and family that begins at diagnosis and treatment of a serious or terminal illness. This type of care is focused on providing relief from symptoms and stress of the illness with the goal of improving quality of life for you and your family.

Physician: A person who is qualified to practice medicine.

Physician Services: Health care services you receive from a physician, nurse practitioner or physician assistant.

Plan (or Health Plan): Company providing you with health care services.

Postnatal: Pregnancy health care for a mother who has just given birth to a child.

Preauthorization: Means approval necessary prior to the receipt of care. May also be referred to as prior authorization or precertification.

Prenatal: Pregnancy health care for expectant mothers, prior to the birth of a child.

Prescription Drug Coverage: Refers to how the health plan helps pay for its members' prescription drugs and medications.

Prescription Drugs: A drug that, by law, requires a provider to order it before a beneficiary can receive it.

Primary Care: Services from a primary care provider that help you prevent illness (check-up, immunization) to manage a health condition you already have (like diabetes).

Primary Care Provider (PCP) (or Primary Care Physician): The doctor or clinic where you get your primary care (immunizations, well-visits, sick visits). Your PCP should also be available after hours and on weekends to give you medical advice. They also refer you to specialists if you need it. You are not required to call your PCP before going to the emergency room.

Prior Authorization (or Preauthorization): Approval you must have from your health plan before you can get or continue getting certain health care services or medicines.

Provider: A health care professional or a facility that delivers health care services, like a doctor, hospital or pharmacy.

Provider Network (or Network): A group of doctors, hospitals, pharmacies and other health professionals who have a contract with your health plan to provide health care services for members.

Referrals: A documented order from your provider for you to see a specialist or receive certain medical services.

Rehabilitation and Therapy Services and Devices: Health care services and equipment that help you recover from an illness, accident, injury or surgery. These services can include physical or speech therapy.

Service Limit: The maximum amount of a specific service that can be received.

Skilled Nursing Care: Health care services that require the skill of a licensed nurse.

Specialist: A provider who is trained and practices in a specific area of medicine.

State Fair Hearing: When you do not agree with your health plan's resolution, you can ask for the State of NM HSD to review it.

Substance Use Disorder: A medical disorder that includes the misuse or addiction to alcohol and/or legal or illegal drugs.

Telehealth: Use of two-way real-time interactive audio and video to provide and support health care services when participants are in different physical locations.

Transition of Care: Process of assisting you to move between health plans or to another Medicaid program. The term Transition of Care also applies to the assistance provided to you when your provider is not enrolled in the health plan.

Urgent Care: Care for a health condition that needs prompt medical attention but is not an emergency medical condition. You can get urgent care in a walk-in clinic for a non-life-threatening illness or injury.

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Health plan highlights

Getting started

Member Services

Welcome to UnitedHealthcare Community Plan. We are pleased to serve you as a Turquoise Care member. You may call our Member Services department at **1-877-236-0826**, or **TTY 711**, to help resolve issues, help you find providers, get materials sent out in the format you want and connect you with resources in your community.

If you are interested in more information about UnitedHealthcare, our operations, physicians or senior Staff's incentive plans, please submit written request to **nmmemberinfo@uhc.com**.

We speak your language

If you speak a language other than English, we can provide translated printed materials. Or we can provide an interpreter who can help you understand these materials. You'll find more information about Interpretive Services and Language Assistance in the section called Other Plan Details. Or call Member Services at **1-877-236-0826**, TTY **711**.

Si usted habla un idioma que no sea inglés, podemos proporcionar materiales impresos traducidos. O podemos proporcionar un intérprete que puede ayudar a entender estos materiales. Encontrará más información acerca de servicios de interpretación y asistencia lingüística en la sección Otros detalles del plan. O llame a Servicios para Miembros al **1-877-236-0826**, TTY **711**.

Information on your plan

You can find a complete description of your benefits and services included in your plan in the UnitedHealthcare Community Plan Member Handbook, mailed separately. You can find the handbook online at **myuhc.com/CommunityPlan/nm**.

Finding a provider

You can access a copy of our Community Health Plan Provider Directory on our website at **myuhc.com/CommunityPlan/nm**. You can also call Member Services to obtain a copy of the directory. Providers in the printed directory are current as of the date on the cover. The online directory is updated more frequently than the printed directory.

You can access the website 24/7 access to plan details.

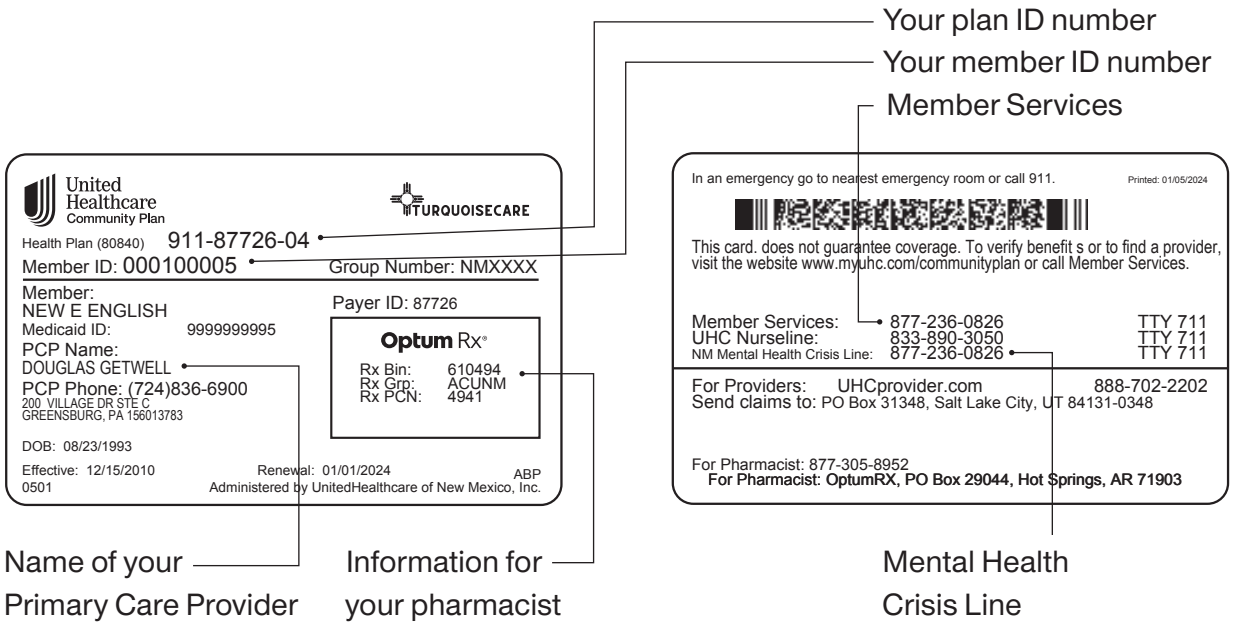
Go to **myuhc.com/communityplan/nm** to sign up for web access to your account. This secure website keeps all of your health information in one place. In addition to plan details, the site includes useful tools that can help you:

- Print a new member ID card
- Find a provider or pharmacy
- Access formulary and search for medicine on preferred drug list.
  IHS and Tribal 638 pharmacies are exempt from the preferred drug list/formulary.
- Get benefit details
- Download a new Member Handbook or copy of the formulary

Complete your Health Risk Assessment

A Health Risk Assessment (HRA) is a short and easy survey that asks you simple questions about your lifestyle and health. It helps us to get to know you better and match you with benefits and services. You should complete your HRA within the first 30 days of becoming a member, or as soon as you can. Please call Member Services at **1-877-236-0826**, or TTY **711** to complete your HRA over the phone. You may also visit **myuhc.com/communityplan/nm** to complete the form online.

Member ID card



Your member ID card holds a lot of important information. It gives you access to your covered benefits. You should have received your member ID card in the mail within 20 days of joining UnitedHealthcare Community Plan. Each family member will have their own card. Check to make sure all the information is correct. If any information is wrong, call Member Services at **1-877-236-0826**, TTY **711**.

- Take your member ID card to your appointments
- Show it when you fill a prescription
- Have it ready when you call Member Services; this helps us serve you better
- Do not let someone else use your card(s). It is against the law.

Show your card. Always show your UnitedHealthcare member ID card when you get care. This helps ensure you get all the benefits available to you, and prevents billing mistakes.

Bring your Medicare card and your UnitedHealthcare Community Plan ID card to all doctor and pharmacy visits.

Benefits at a glance

As a UnitedHealthcare Community Plan member, you have a variety of health care benefits and services available to you. Here is a brief overview. You'll find a complete listing in the Benefits section.

Primary care services

The doctor or clinic where you get your primary care (immunizations, well-visits, sick visits). Your PCP should also be available after hours and on weekends to give you medical advice. They also refer you to specialists (cardiologists, behavioral health providers) if you need it. PCP referral for behavioral health assist member in finding provider, however members may self-refer to behavioral health services, referral is not required.

Provider network

You can choose any PCP from our large network of providers. Our network also includes specialists, hospitals and pharmacies — giving you many options for your health care. Find a complete list of network providers at **myuhc.com/communityplan/nm**.

Specialist services

Your coverage includes services from specialists. Specialists are doctors or nurses who are highly trained to treat certain conditions. You may need a referral from your PCP first. See page 32.

Medicines

Your plan covers prescription drugs for members of all ages. Also covered: insulin, needles and syringes, birth control, coated aspirin for arthritis, iron pills and chewable vitamins.

Hospital services

You're covered for hospital stays. You're also covered for outpatient services. These are services you get in the hospital without spending the night.

Laboratory services

Covered services include tests and X-rays that help find the cause of illness.

Well-child visits

All well-child visits and immunizations are covered by your plan.

Maternity and pregnancy care

You are covered for doctor visits before and after your baby is born. That includes hospital stays. If needed, we also cover home visits after the baby is born.

Family planning

You are covered for services that help you manage the timing of pregnancies. These include birth control products and procedures.

Vision care

Your vision benefits may include routine eye exams and glasses. Your benefits may differ based on your Medicaid eligibility. Standard Medicaid provides more comprehensive vision coverage, including eyeglasses for children, compared to the Alternative Benefit Package (ABP). ABP offers limited vision care primarily for members ages 19–20; limited vision hardware is covered primarily for members ages 19–20 with specific medical conditions.

March Vision manages your vision benefits. You may call Member Services at **1-877-236-0826** or visit their website at **www.marchvisioncare.com** to find a vision provider.

Hearing care

If you have a hearing impairment, certain services are available.

Dental care

Your dental benefits are covered by UnitedHealthcare Community Plan. Your benefits may differ based on your Medicaid eligibility. Standard Medicaid and the Alternative Benefit Package (ABP) both cover essential dental services. ABP covers preventive dental services based on a periodicity schedule.

Member support

Children in State Custody (CISC)

Native American CISC members may elect to enroll in the UnitedHealthcare Community Plan. All non-Native American Turquoise Care CISC members are enrolled in the Presbyterian Health Plan per HSD contracting. Native American CISC members have a dedicated care coordination team led by a Registered Nurse (RN). If you are a Native American member and select Community Plan we will follow our transition of care plan and work with your current provider for continuity of care.

Member switch and disenrollment requests

You can switch to another managed care plan at any time if there is "good cause." You or your representative must make the request in writing and send it to HSD. Here are examples of when you may make a special request. Community Health Plan of NM Turquoise Care:

- Does not cover the service because of moral or religious reasons
- Has been given penalties by HSD
- In-network providers are not available to perform multiple services at the same time
- You do not have access to in-network providers for your health care needs
- Moved out-of-state
- Poor quality of care

Written request for switch or disenrollment must be sent to HSD for review, or you may call the New Mexico Medicaid Call Center toll-free at 1-800-283-4465. HSD must review and approve or deny the request no later than at least 60 days before the start of each enrollment period.

If HSD does not respond in time, then the request is approved. Send your written request to:

HSD Communication and Education Bureau
P.O. Box 2348
Santa Fe, NM 87504-2348

For help with switch or disenrollment, call the Member Services Center at **1-877-236-0826**, TTY **711**. If HSD denies your disenrollment request, then you may ask for a fair hearing. See page 124 for more information on fair hearings.

Member Services is available to assist you

Member Services can help with your questions or concerns. This includes:

- Understanding your benefits
- Help getting a replacement member ID card
- Finding a doctor or urgent care clinic

Call **1-877-236-0826**, TTY **711**, 8:00 a.m.–5:00 p.m. MT., Monday–Friday.

Care Coordination program

If you have a chronic health condition, like asthma or diabetes, you may benefit from our Care Coordinator program. We can help with a number of things, like scheduling doctor appointments and keeping your providers informed about the care you get. To learn more, call **1-877-236-0826**, TTY **711**.

Health plan highlights

Transportation services are available

As a UnitedHealthcare member, non-emergency transportation and/or mileage reimbursement are available to and from physical health, behavioral health, and pharmacy. To request transportation or mileage reimbursement forms, please call **1-877-236-0826**, TTY **711**.

Native American members

Turquoise Care at UnitedHealthcare Community Plan of New Mexico offers programs for the Native American population. With the help of its committed team, Community Plan will work in partnership with all of New Mexico's Pueblos, Tribes, and the Navajo Nation to ensure compliance with cultural and linguistic competence. To provide fair access for the Native American community in urban and reservation settings, we will work with our tribal partners to address health inequalities, advance health equity, and build and maintain cultural competency. Native American's enrolled for Medicaid, will continue have access to Indian Health Services, Tribal 638 Facilities, Urban Indian Health Centers (I/T/U) and our network of providers. For more information, members may call Member Services at **1-877-236-0826**, TTY **711**.

Emergencies

In case of emergency, call **911**

Important numbers

Member Services **1-877-236-0826**

Receiving care outside of New Mexico

If you are outside of New Mexico but within the United States and need emergency services, go to the nearest emergency room. Claims for covered emergency medical/surgical services received outside New Mexico from providers that do not contract Turquoise Care providers should also be filed to the address on your ID card. If a provider will not file a claim for you, ask for an itemized bill and complete a claim form the same way you would for services received from any other out-of-network provider.

If you see an out-of-state provider for non-emergency services, you must first receive prior authorization. If you do not get a prior authorization, the services will not be covered.

For those who have BOTH Medicare and Medicaid coverage

If you have both Medicare and Medicaid

If you have both Medicare and Medicaid, you have more than one insurance coverage:

- Medicare is considered your primary insurance
- Turquoise Care (Medicaid) is your secondary insurance

Your Turquoise Care benefits will not change your primary insurance benefits. Your Care Coordinator will assist you in working with your primary insurance to help set up your health care.

If you have both Medicare and Turquoise Care, Medicare Part D will cover your medication (you will still have to pay Medicare Part D copays), unless you live in a nursing facility. If you have Medicare, you can use your current doctor. You can get Medicare specialty services without approval from Turquoise Care.

We will work with your doctor for the services you get through Turquoise Care. We can help you pick a doctor if you do not have one. This doctor can set up your Turquoise Care and Medicare services. If you are in a Medicare Advantage Plan, your primary care provider (PCP) is your Medicare Advantage doctor.

You do not have to pick another primary care provider for Turquoise Care. Medicare or your Medicare Advantage Plan will pay for your services before Turquoise Care. Turquoise Care may cover some services that are not covered by Medicare.

If you have questions, call Member Services at **1-877-236-0826**. For hearing impaired, dial **711** for TTY service.

Turquoise rewards

The Turquoise Rewards program is part of New Mexico's Turquoise Care. Turquoise Rewards allows you to earn points for completing certain health activities. You can use your reward points to shop for hundreds of fun, healthy items in the Turquoise Rewards catalog!

For example, you can earn reward points for:

- Attending an annual checkup with your primary care provider
- Getting a flu shot
- Completing health screenings, like a mammogram, cervical cancer screening, and others
- Keeping up to date on your children's immunizations
- ... And many more!

Visit **turquoiserewards.com** to see all the eligible activities.

As a Turquoise Care member, you are automatically enrolled in Turquoise Rewards! To learn more, or to spend your reward points, visit **turquoiserewards.com**. You can also call **1-877-806-8964** (TTY **1-844-488-9722**) between 8:00 a.m. and 6:00 p.m. MT, Monday through Friday.

Reward points have no cash value and can only be used to shop for items in the rewards catalog. Exclusions and restrictions apply.

These services are provided in part by the State of New Mexico.

You can start using your pharmacy benefit right away

Your plan covers a long list of medicines, or prescription drugs. Medicines that are covered are on the plan's Preferred Drug List. Your doctor uses this list to make sure the medicines you need are covered by your plan. You can find the Preferred Drug List online at **myuhc.com/communityplan/nm**. You can also search by a medicine name on the website. It's easy to start getting your prescriptions filled. Here's how:

1. Are your medicines included on the Preferred Drug List?

Yes

If your medicines are included on the Preferred Drug List, you're all set. Be sure to show your pharmacist your new member ID card every time you get your prescriptions filled.

 Questions? Visit **myuhc.com/communityplan/nm**, or call Member Services at **1-877-236-0826**,TTY **711**.

No

If your prescriptions are not on the Preferred Drug List, schedule an appointment with your doctor within the next 30 days. They may be able to help you switch to a drug that is on the Preferred Drug List. Your doctor can also ask for an exception if they think you need a medicine that is not on the list.

Not sure

View the Preferred Drug List online at **myuhc.com/communityplan/nm**. You can also call Member Services. We're here to help.

2. Do you have a prescription?

When you have a prescription from your doctor, or need to refill your prescription, go to a network pharmacy. Show the pharmacist your member ID card. You can find a list of network pharmacies in the Provider Directory online at **myuhc.com/communityplan/nm**, or you can call Member Services.

3. Do you need to refill a medication that's not on the Preferred Drug List?

If you need refills of medicines that are not on the Preferred Drug List. IHS and Tribal 638 pharmacies are exempt from the preferred drug list/formulary. You can get a temporary 3-day supply, to do so, visit a network pharmacy and show your member ID card. If you don't have your member ID card, you can show the pharmacist the information below. Talk to your doctor about your prescription options.

Attention Pharmacist

Please process this UnitedHealthcare Community Plan member's claim using:

BIN: 610494
Processor Control Number: 4941
Group: ACUNM

If you receive a message that the member's medication needs a prior authorization or is not on our formulary, please call **OptumRx®** at **1-877-305-8952** for a transitional supply override.

Care coordination

Care coordination helps you get access to the care you need. UnitedHealthcare Community Plan has Care Coordinators for anyone in Turquoise Care. Care Coordinators help you meet your health needs. A Care Coordinator is your main point of contact. They may contact you by phone or in person depending on your level of need. A Care Coordinator does not provide direct care services, such as home health care, meal preparation, therapy, etc. A Care Coordinator is someone that looks at your physical and/or behavioral health needs and works directly with you and your family to get the services needed to improve your health. Members may self-refer to behavioral health services.

The Care Coordinator can also connect you with a Behavioral Health Peer Support Specialist, who is an individual who has personal experience with the type of issues you may be struggling to overcome.

How do I get a Care Coordinator?

You'll get a Health Assessment over the phone. If we see that you could use extra assistance, you will be assigned a Care Coordinator. They will contact you by phone. If they are unable to reach you, you will receive a letter from your care coordinator.

How can I contact my Care Coordinator?

Contact your Care Coordinator at **1-877-236-0826**. Once you are assigned a Care Coordinator, you can contact him or her directly as often as you need to.

What if I want a new Care Coordinator?

If you want to change Care Coordinators, call **1-877-236-0826**. We can provide a new one. We will make sure you know how to reach him or her.

Note: You have the right to decline services with a Care Coordinator.

Working with your doctor

- If you do not have a PCP, your Care Coordinator will help you find one
- Your Care Coordinator can help make sure your PCP and other providers are working with you
- Your PCP is advised of any assessments and screenings you have had
- With your permission or consent, a copy of your Care Plan will be sent to your PCP
- Your Care Coordinator works with your PCP to make sure you are involved in programs that can improve your health

- Your Care Coordinator can work with your specialists to share their findings with your PCP. In **most** cases, your permission **will** be needed.
- Your Care Coordinator works with your PCP to make sure you have the services you need when you come out of the hospital
- Your PCP can refer you to other doctors or specialists you may need, including behavioral health services. PCP referral for behavioral health assist member in finding provider, however members may self-refer to behavioral health services, referral is not required.

Complex case management and disease management

Our Care Coordinators can help you manage your medical and behavioral health conditions. They live and work in your community. They understand your issues. They will work with you and your doctors to help you get the care you need.

Our Care Coordinators can help you:

- Get information to help you to stay well
- Get assistance from a behavioral health peer support specialist
- Learn how to take care of yourself
- Find a behavioral health specialist in your area
- Find a PCP, specialist or urgent care facility
- Make appointments
- Get to and from doctor visits, pharmacy visits and behavioral health visits
- Arrange for supplies and home health care for you
- Find community resources and peer/family supports
- Give you resources to help you quit smoking
- Give you information on specific conditions

Care Coordinators can help you with:

- Asthma
- Depression
- Diabetes
- Congestive Heart Failure (CHF)
- Chronic Obstructive Pulmonary Disease (COPD)
- Coronary Artery Disease (CAD)
- Lung disease
- Pregnancy
- High blood pressure
- Obesity
- Special needs
- Transplants and information on your condition(s) and recovery and resiliency
- Any other conditions that need case management

What is a UnitedHealthcare Ombudsman?

Your Ombudsman:

- Is a neutral party and a member advocate. The ombudsman will work directly with the member in order to research and address member concerns.
- Is a resource for finding a solution
- Will work with members to help them understand their rights and their responsibilities

What are the limitations of the Ombudsman?

- The ombudsman will not file appeals or grievances on behalf of the members
- The ombudsman does not have the authority to override policies or procedures
- The ombudsman will not make decisions for the members
- Members have the right to refuse ombudsman services. An exception for ombudsman services to continue without member consent is in a life-threatening event to the member or to others. If this occurs, the Ombudsman will report this event.

Contact information for members:

The direct telephone number to the Ombudsman's office is **1-877-236-0826**, TTY **711**.

How can a member reach their UnitedHealthcare Ombudsman?

- By email: **NM_Ombudsman@uhc.com**
- By phone: Member Services at **1-877-236-0826**; TTY **711** for hearing impaired

Going to the doctor

Your Primary Care Provider (PCP)

We call the main doctor, nurse practitioner/physician assistant you see a Primary Care Provider, or PCP. When you see the same PCP over time, it's easier to develop a relationship with them. Each family member can have their own PCP, or you may all choose to see the same person. You will see your PCP for:

- Routine care, including yearly checkups
- Coordinate your care with a specialist
- Treatment of your chronic health care needs and any changes that occur in your health
- Other health concerns

You have options

You can choose between many types of network providers for your PCP. Some types of PCPs include:

- Family doctor (also called a general practitioner) — cares for children and adults
- Gynecologist (GYN) — cares for women
- Internal medicine doctor (also called an internist) — cares for adults
- Nurse Practitioner (NP) — cares for children and adults
- Obstetrician (OB) — cares for pregnant women
- Pediatrician — cares for children
- Physician Assistant (PA) — cares for children and adults

What is a Network Provider?

Network Providers have contracted with UnitedHealthcare Community Plan to care for our members. You don't need to call us before seeing one of these providers. There may be times when you need to get services outside of our network. Call Member Services to learn if they are covered in full. You may have to pay for those services.

Choosing your PCP

If you've been seeing a doctor before becoming a UnitedHealthcare member, check to see if your doctor is in our network. If you're looking for a new PCP, consider choosing one who's close to your home or work. This may make it easier to get to appointments.

There are three ways to find the right PCP for you.

1. Use the Doctor Lookup tool at **myuhc.com/communityplan/nm**.
2. Look through our printed Provider Directory.
3. Call Member Services at **1-877-236-0826**, TTY **711**.
   We can answer your questions and help you find a PCP close to you.

Once you choose a PCP, call Member Services and let us know. We will make sure your records are updated. If you don't want to choose a PCP, UnitedHealthcare will choose one for you, based on your location and language spoken.

Changing your PCP

It's important that you like and trust your PCP. You can change PCPs at any time. Call Member Services and we can help you make the change.

Learn more about network doctors

You can learn information about network doctors, such as board certifications, and languages they speak, at **myuhc.com/communityplan/nm**, or by calling Member Services.

Annual checkups

The importance of your annual checkup

You don't have to be sick to go to the doctor. In fact, yearly checkups with your PCP can help keep you healthy. In addition to checking on your general health, your PCP will make sure you get the screenings, tests and shots you need. And if there is a health problem, they're usually much easier to treat when caught early.

Here are some important screenings. How often you get a screening is based on your age and risk factors. Talk to your doctor about what's right for you.

- Blood pressure check
- Weight
- Review of risk factors for heart disease
- Colon cancer screening
- Review of your medications

For women

- Pap smear — helps detect cervical cancer
- Breast exam/Mammography — helps detect breast cancer

For men

- Testes exam — helps detect testicular cancer
- Prostate exam — helps detect prostate cancer

Well-child visits

Well-child visits are a time for your PCP to see how your child is growing and developing. They will also give the needed screenings, like speech and hearing tests, and immunizations during these visits. These routine visits are also a great time for you to ask any questions you have about your child's behavior and overall well-being, including:

- Eating
- Sleeping
- Behavior
- Social interactions
- Physical activity

Well-child health check schedule

Under age 1:

- 3–5 days
- 1 month
- 2 months
- 4 months
- 6 months
- 9 months

Ages 1 to 30 months:

- 12 months
- 15 months
- 18 months
- 24 months
- 30 months

Ages 3 to 20 years:

- Each year

Here are shots the doctor will likely give, and how they protect your child:

- **Hepatitis A and Hepatitis B:** prevent two common liver infections
- **Rotavirus:** protects against a virus that causes severe diarrhea
- **Diphtheria:** prevents a dangerous throat infection
- **Tetanus:** prevents a dangerous nerve disease
- **Pertussis:** prevents whooping cough
- **HiB:** prevents childhood meningitis
- **Meningococcal:** prevents bacterial meningitis
- **Polio:** prevents a virus that causes paralysis
- **MMR:** prevents measles, mumps and rubella (German measles)
- **Varicella:** prevents chickenpox
- **Influenza:** protects against the flu virus
- **Pneumococcal:** prevents ear infections, blood infections, pneumonia and bacterial meningitis
- **HPV:** protects against a sexually transmitted virus that can lead to cervical cancer in women and genital warts in men
- **Covid-19:** vaccine helps reduce the risk of illness from COVID-19
- **RSV:** protects you from getting Respiratory Syncytial Virus

Making an appointment with your PCP

Call your doctor's office directly. The number should be on your member ID card. When you call to make an appointment, be sure to tell the office what you're coming in for. This will help make sure you get the care you need, when you need it. This is how quickly you can expect to be seen:

How long it should take to see your PCP:	
Emergency	Immediately or sent to an emergency facility
Urgent (but not an emergency)	Within 1 day or 24 hours
Routine	Within 14 days
Preventive, well-child and regular	Within 1 month

Preparing for your PCP appointment

Before the visit

1. Go in knowing what you want to get out of the visit (relief from symptoms, a referral to a specialist, specific information, etc.).
2. Make note of any new symptoms and when they started.
3. Make a list of any drugs or vitamins you take on a regular basis.

During the visit

When you are with the doctor, feel free to:

- Ask questions
- Take notes if it helps you remember
- Ask the doctor to speak slowly or explain anything you don't understand
- Ask for more information about any medicines, treatments or conditions

UnitedHealthcare Nurseline services – Your 24-hour health information resource

When you're sick or injured, it can be difficult to make health care decisions. You may not know if you should go to the emergency room, visit an urgent care center, make a provider appointment or use self-care. An experienced UnitedHealthcare Nurseline nurse can give you information to help you decide.

Nurses can provide information and support for many health situations and concerns, including:

- Minor injuries
- Common illnesses
- Self-care tips and treatment options
- Recent diagnoses and chronic conditions
- Choosing appropriate medical care
- Illness prevention
- Nutrition and fitness
- Questions to ask your provider
- How to take medication safely
- Men's, women's and children's health

You may just be curious about a health issue and want to learn more. Experienced registered nurses can provide you with information, support and education for any health-related question or concern.

Simply call the toll-free number **1-833-890-3050** or TTY **711** for the hearing impaired. You can call the toll-free UnitedHealthcare Nurseline number any time, 24 hours a day, 7 days a week. And, there's no limit to the number of times you can call.

Referrals and specialists

A referral is when your PCP says you need to go to another doctor who focuses on caring for a certain part of the body or treating a specific condition. This other doctor is called a specialist. You may see any specialist within our network without a referral. If your doctor wants you to see a specialist that you do not want to see, you can ask your PCP to give you another name. A couple of examples of specialists include:

- Cardiologist — for problems with the heart
- Pulmonologist — for problems with the lungs and breathing

You do not need a referral from your PCP for:

- Urgent care
- Emergency services
- Mental health
- Substance abuse
- Sexually transmitted disease (STD) testing and treatment — includes annual exam and up to five gynecologist (GYN) visits per year
- Routine eye exams
- Education classes — including parenting, smoking cessation and childbirth

Getting a second opinion

A second opinion is when you want to see a second doctor for the same health concern. You can get a second opinion from a network provider at no cost for any of your covered benefits. This is your choice. You are not required to get a second opinion.

Prior authorizations

In some cases your provider must get permission from the health plan before giving you a certain service. This is called prior authorization. This is your provider's responsibility. If they do not get prior authorization, you will not be able to get those services.

You do not need prior authorization for advanced imaging services that take place in an emergency room, observation unit, urgent care facility or during an inpatient stay. You do not need a prior authorization for emergencies or urgent care. You also do not need prior authorization to see a women's health care provider for women's health services or if you are pregnant.

Requirements to get services

What is prior authorization?

You may need prior authorization to get some services under Turquoise Care. Your provider works with UnitedHealthcare Community Plan to get Prior Authorization. Prior authorization is needed if you get services from a provider that is not in the UnitedHealthcare Community Plan Turquoise Care network. You do not need prior authorization for emergencies or to see a doctor if you are pregnant.

You may need prior authorization for these services:

- Inpatient behavioral health
- Attendant care services
- Behavioral health
- Community transition services
- Medical equipment and medical supplies
- Emergency response system (in-home)
- Environmental modifications
- Home health
- Inpatient hospital
- Nursing facilities
- Occupational therapy
- Physical therapy
- Private duty nursing
- Prosthetics and orthotics
- Respite
- Speech therapy
- Transplant
- Outpatient surgeries

Call Member Services or your Care Coordinator if you have questions about prior authorization.

Attention: American Indians and Alaskan Natives receiving care at I.H.S. or Tribally operated facilities do not need a prior authorization. All I.H.S. and 638 programs are considered in-network providers.

What if I want a second opinion?

You can get a second opinion for your health care from an in-network provider or, if one is not available, from an out-of-network provider at no cost to you. Call your primary care provider or your Care Coordinator. You can also call Member Services.

Special options for Native American members

Native American members may go to an Indian Health Service (IHS) or Tribal health care facility. There is no need for a referral or prior authorization.

Continued care if your PCP leaves the network

Sometimes PCPs leave the network. If this happens to your PCP, you will receive a letter from us letting you know. Sometimes UnitedHealthcare Community Plan will pay for you to get covered services from doctors for a short time after they leave the network. You may be able to get continued care and treatment when your doctor leaves the network if you are being actively treated for a serious medical problem. For example, you may qualify if you are getting chemotherapy for cancer or are at least six months pregnant when your doctor leaves the network. To ask for this, please call your doctor. Ask them to request an authorization for continued care and treatment from UnitedHealthcare.

Transportation

UnitedHealthcare Community Plan coordinates your transportation benefit. They offer routine transportation to medical, dental and behavioral health appointments as well as to pick up your prescriptions at a nearby pharmacy. You can reach a representative 8:00 a.m.–5:00 p.m., Monday–Friday. The reservation line is closed on National Holidays and weekends.

How do I schedule a ride?

You must call at least **3 business days** before your appointment. Three business days does not include weekends, holidays, or the day of the call. You can call for a ride up to two weeks before your appointment. You must have your medical or behavioral health appointment date, time and address available.

- Open Monday through Friday
- 8:00 a.m. to 5:00 p.m. Mountain Time
- Closed Saturdays and Sundays
- Closed on national holidays
- Calls for trips for urgent/same-day appointments/facility discharges and Ride Assist are handled 24/7, 365 days at **1-877-236-0826**
  - Reservation: **1-877-236-0826**
  - Ride Assist (Where's My Ride?): **1-877-236-0826**
  - Hearing impaired (TTY): **1-877-236-0826**

Here are examples of situations when you might need urgent transportation:

- Hospital discharges
- Follow-up appointments
- Pre-operative appointments
- Admissions
- Out-patient surgery
- Appointments for new medical conditions that you must be seen for
- Dialysis
- Chemotherapy
- Radiation

Do they offer gas or mileage reimbursement?

Yes, but you must speak with a representative from UnitedHealthcare Community Plan before your appointment. They will send you a voucher form with instructions. To obtain reimbursement:

- The provider you are seeing must fill out the form or attach a doctor note
- You are responsible for sending the paperwork back to UnitedHealthcare Community Plan for payment
- If you have receipts for reimbursement, make copies and include them with your paperwork back to UnitedHealthcare Community Plan

What if I need to see a provider in another city?

You may need to see a provider in another city or state because there is not one in your city or town. Work with your Care Coordinator to arrange the transportation and/or lodging through UnitedHealthcare Community Plan. The services must be medically necessary and prior approval must be obtained before seeing a provider out of the UnitedHealthcare Community Plan Turquoise Care network.

Note: The most cost-effective mode of transportation will be utilized. For example: cab, wheelchair van (if applicable) or bus.

What if I have to stay overnight in another city?

The appointment must be at least 4 hours away from your primary residence and it must be medically necessary. Please work with your Care Coordinator to arrange lodging and make sure UnitedHealthcare Community Plan is given advance notice. UnitedHealthcare Community Plan will send you a voucher form with instructions for reimbursement of meal expenses.

Not all appointments qualify for this service.

Hospitals and emergencies

Emergency care

Hospital emergency rooms are there to offer emergency treatment for trauma, serious injury and life-threatening symptoms. Some reasons to go to the ER include:

- Serious illness
- Broken bones
- Heart attack
- Poisoning
- Severe cuts or burns

UnitedHealthcare Community Plan covers any emergency care you need throughout the United States and its territories. Within 24 hours after your visit, call Member Services at **1-877-236-0826**, TTY **711**.

Don't wait

If you need emergency care, call **911** or go to the nearest hospital. For members who are experiencing a mental health crisis or emergency, call **988**. Prior authorization is not needed for emergency services.

Urgent care

Urgent care clinics are there for you when you need to see a doctor for a non-life-threatening condition but your PCP isn't available or it's after clinic hours. Common health issues ideal for urgent care include:

- Sore throat
- Ear infection
- Minor cuts or burns
- Flu
- Low-grade fever
- Sprains

If you or your children have an urgent problem, call your PCP first. Your doctor can help you get the right kind of care. Your doctor may tell you to go to urgent care or the emergency room.

Planning ahead

It's good to know what urgent care clinic is nearest to you. You can find a list of urgent care clinics in your Provider Directory. Or you can call Member Services at **1-877-236-0826**, TTY **711**.

Hospital services

There are times when your health may require you to go to the hospital. There are both inpatient and outpatient hospital services.

Outpatient services include X-rays, lab tests and minor surgeries. Your PCP will tell you if you need outpatient services. Your doctor's office can help you schedule them.

Inpatient services require you to stay overnight at the hospital. These can include serious illness, surgery or having a baby.

Inpatient services require you to be admitted (called a hospital admission) to the hospital. The hospital will contact UnitedHealthcare Community Plan and ask for authorization for your care.

Going to the hospital

You should go to the hospital only if you need emergency care or if your doctor told you to go.

Emergency dental care

Emergency dental care services to control pain, bleeding or infection are covered by your plan.

No medical coverage outside of U.S.

If you are outside of the United States and need medical care, any health care services you receive will not be covered by UnitedHealthcare Community Plan. Medicaid cannot pay for any medical services you get outside of the United States.

Pharmacy

Prescription drugs

Your benefits include prescription drugs

UnitedHealthcare Community Plan covers hundreds of prescription drugs from hundreds of pharmacies. The full list of covered drugs is included in the Preferred Drug List. You can fill your prescription at any in-network pharmacy. All you have to do is show your member ID card.

Generic and brand name drugs

UnitedHealthcare Community Plan encourages all members to use generic drugs when possible. Generic drugs have the same ingredients as brand name drugs — they often cost less, but they work the same.

In some cases, brand name drugs are covered. Some of these may require specific information from your provider or prior authorization by UnitedHealthcare Community Plan.

If you are in UnitedHealthcare Community Plan Turquoise Care and have Medicare, your Medicare Part D plan will cover most of your drugs. There are a few over-the-counter medications not covered by Part D that Turquoise Care may cover. Please see the state pharmacy product list.

What is the Preferred Drug List?

This is a list of drugs covered under your plan. You can find the complete list in your formulary, or online at **myuhc.com/communityplan/nm**. IHS and Tribal 638 pharmacies are exempt from the preferred drug list/formulary.

Changes to the Preferred Drug List

The list of covered drugs is reviewed on a regular basis and may change when new generic drugs are available. There are some members who may have to pay a small amount (called a copay) for their prescriptions.

Over-the-Counter (OTC) medicines

UnitedHealthcare Community Plan covers some over-the-counter (OTC) medications. An in-network provider must write you a prescription for the OTC medication you need. The supply is limited to 30 days. Then all you have to do is take your prescription and member ID card into any network pharmacy to fill the prescription. Some covered OTCs include:

- Low dose aspirin
- Prenatal drug items
- Contraceptives

For a complete list of covered OTCs, go to **myuhc.com/communityplan/nm**. Or call Member Services at **1-877-236-0826**, TTY **711**.

Prescription medicines

For a complete list of covered Prescription Medicines, go to **myuhc.com/communityplan/nm**. Or call Member Services at **1-877-236-0826**, TTY **711**.

Pharmacy and therapeutics committee

UnitedHealthcare Community Plan covers many drugs. We use a **formulary**, also called a Preferred Drug List, for your prescription coverage. A formulary is a list of medicines that a health plan will cover. Having a formulary helps your doctor prescribe medicines for you. New drugs and forms of treatment are being introduced every year after review by a committee, and UnitedHealthcare Community Plan adds drugs to its formulary as needed. IHS and Tribal 638 pharmacies are exempt from the preferred drug list/formulary.

Pharmacy Lock-In

Some members may need to be placed in a Pharmacy Lock-In Program. This program is also called the Pharmacy Home Program. This program will help your pharmacist keep track of all medications that you may be taking in order to:

- Protect your health and keep you safe
- Provide continuity of care
- Avoid duplication of services by other providers
- Avoid inappropriate or unnecessary utilization of your Medicaid benefits and;
- Avoid excessive utilization of prescription medications

This program requires that you get all of your prescriptions from one pharmacy. This program doesn't change your current healthcare benefits and doesn't apply to specialty drugs.

How do I know if I am in a Pharmacy Lock-In Program?

We will send you a letter thirty (30) days before the effective or start date of the Pharmacy Home Program.

The letter will:

- Explain the Lock-In Program
- Give you the opportunity to choose a pharmacy to fill your prescription

What do I have to do?

Please ask your providers to send your prescriptions to the pharmacy that is listed in the letter that you received. It is important that you go to the pharmacy that is listed in the letter. If you go to another pharmacy, your prescription will be denied and you will be redirected to go to the correct pharmacy. We want to make sure that there is no delay in getting your medication.

Can I change my pharmacy?

Yes, you have thirty (30) days from the date of the letter that you received to change your pharmacy. In special cases, you may be able to request a pharmacy change after thirty (30) days. You will still only be able to use one pharmacy. To change your pharmacy, call Member Services at the number below.

Questions?

If you have any questions or need help, please call Member Services toll-free at **1-877-236-0826**.

Provider Lock-In

Some UnitedHealthcare Community Plan members will be assigned a provider lock-in. In this case, members must receive prescriptions from a single provider for at least one year. This is based on prior medication use, including overuse of pharmacy benefit, narcotics, provider locations and other information.

Members of this program will be sent a letter with the name of the physician they are required to use. If you get this letter, you have 30 days from the date of the letter to request a change of provider. To change providers during this time, call Member Services at **1-877-236-0826**, TTY **711**. After 30 days from the date of the letter, you will need to make your request in writing. Send your request to:

UnitedHealthcare Community Plan
Pharmacy Department
P.O. Box 41566
Philadelphia, PA 19101

Benefits

Standard benefits covered by UnitedHealthcare Community Plan

As a member of UnitedHealthcare Community Plan, you are covered for the following services. Remember to always show your current member ID card when getting services. It confirms your coverage. If a provider tells you a service is not covered by UnitedHealthcare and you still want these services, you may be responsible for payment. You can always call Member Services at **1-877-236-0826**, TTY **711**, to ask questions about benefits.

For Alternative Benefit Package (ABP) members, please see page 82.

What are my health care benefits?

UnitedHealthcare Community Plan Turquoise Care gives you health care that is medically necessary. The amount, duration, and scope of benefits you can get are based on your needs and approved services, as determined by the State of New Mexico. **Some benefits and services require preauthorization.** Preauthorization determines whether the services or benefits are necessary. There is no cost for eligible services.

Medically Necessary means care that is:

1. Needed to prevent, diagnose, or treat medical conditions, or care needed to attain, maintain, or regain functional capacity.
2. Given in the right amount and place for health needs.
3. Per professional standards and national guidelines.
4. For health needs and not primarily for the convenience of the member, provider, or UnitedHealthcare Community Plan.

If you need help accessing services under Turquoise Care, please call Member Services at **1-877-236-0826** and ask for Care Coordination.

Members can locate a provider through our online Provider Directory available at **myuhc.com/communityplan/nm** or by calling Member Services and asking for Care Coordination at **1-877-236-0826**. If you need help accessing any services or referrals to another provider, please reach out to your doctor or call Member Services and ask for Care Coordination.

Services included under Turquoise Care — There is no cost share for eligible services

Services	Coverage
Accredited Residential SUD Treatment Centers (Adult)	Covered.
Accredited Residential Treatment Center Services	Covered.
Adult Day Health	Covered for ABCB/SDCB only.
Adult Psychosocial Rehabilitation Services	Covered.
Ambulatory Surgical Center Services	Covered.
Anesthesia Services	Covered.
Applied Behavioral Analysis	Covered with Prior Authorization.
Assertive Community Treatment Services	Covered.
Assisted Living	Covered for ABCB/SDCB only.
Bariatric Surgery	Covered. No limitation on number of surgeries, as long as medical necessity is met.
Behavioral Health Professional Services: Outpatient behavioral health and substance abuse services	Covered.
Behavioral Health Services (Inpatient Psychiatric Hospital, Residential Treatment Center (RTC), Treatment Foster Care (TFC), Group Home and Applied Behavioral Health Analysis (ABA))	Covered with Prior Authorization.
Behavior Management Skills Development Services	Covered.
Behavior Support Consultation	Covered for ABCB/SDCB only.

Note: These services are covered when medically necessary. Other terms, conditions and/or limitations may apply.

Services included under Turquoise Care — There is no cost share for eligible services

Services	Coverage
Care Coordination	Covered.
Case Management	Covered.
Chiropractic	Covered.
Chronic Care Management Services	Covered.
Community Health Workers	Covered.
Community Interveners for the Deaf and Blind	Covered.
Community Transition Services	Covered for ABCB/SDCB only. For those members transitioning home following 90 days or more in a nursing home. Up to a maximum of $500 for Services, and $3,500 for related goods per five-year period. Please contact your care coordinator for more details.
Comprehensive Community Support Services	Covered.
Crisis Services (including telephone, clinic, mobile, and stabilization centers)	Covered.
Crisis Triage Centers (including residential)	Covered.
Day Treatment Services	Covered.
Dental Services (including fluoride varnish)	Covered with limits.

Note: These services are covered when medically necessary. Other terms, conditions and/or limitations may apply.

Services included under Turquoise Care — There is no cost share for eligible services

Services	Coverage
Diagnostic Imaging and Therapeutic Radiology Services	Covered.
Dialectical Behavior Therapy (DBT)	Covered.
Dialysis Services	Covered.
Durable Medical Equipment and Supplies	Covered. Certain supplies also have a monthly volume/quantity limit.
Emergency Response	Covered for ABCB/SDCB only.
Emergency Services (including emergency room visits and psychiatric ER)	Covered.
Employment Supports	Covered for ABCB/SDCB only.
Environmental Modifications	Covered for ABCB/SDCB only, those members with Prior Authorization. Up to a maximum of $5,000 in a five-year period.
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	Covered, as determined by the State. EPSDT applies to members age 1–20. For any EPSDT service, the member needs an examination and prescription for the service from the provider. If you have questions, please call Member Services at **1-877-236-0826**, TTY **711**.

Note: These services are covered when medically necessary. Other terms, conditions and/or limitations may apply.

Services included under Turquoise Care — There is no cost share for eligible services

Services	Coverage
EPSDT Well Child Exam	EPSDT applies to members age 1–20. **Under age one:** six screenings (birth, one, two, four, six and nine months). **Ages one–two:** four screenings (12, 15, 18 and 24 months). **Ages two–three:** one screening (30 months). **Ages three–five:** three screenings (three, four and five years). **Ages six–nine:** two screenings (six and eight years). **Ages 10–14:** four screenings (10, 12, 13 and 14 years). **Ages 15–18:** four screenings (15, 16, 17 and 18 years). **Ages 19–20:** two screenings (19 and 20 years).
EPSDT Behavioral Screenings, Referrals and Treatment	Covered.
EPSDT Oral Health	By 12 months of age need an exam every 6 months.
EPSDT Personal Care Services	Covered. EPSDT applies to members age 1–20.

Note: These services are covered when medically necessary. Other terms, conditions and/or limitations may apply.

Services included under Turquoise Care — There is no cost share for eligible services

Services	Coverage
EPSDT Private Duty Nursing	Covered. EPSDT applies to members age 1–20.
EPSDT Rehabilitation Services	Covered. EPSDT applies to members age 1–20.
EPSDT Vision	By 3 years of age children need a yearly screening.
Experimental or Investigational Procedures, Technology or Non-drug Therapies	Covered with Prior Authorization.
Eye Movement Desensitization and Reprocessing Therapy (EMDR)	Covered.
Family Peer Support Services	Covered.
Family Planning	Covered.
Family Support (Behavioral Health)	
Federally Qualified Health Center Services	Covered.
Functional Family Therapy	Covered.
Hearing Aids and Related Evaluations	Covered. Hearing Aid is limited to one aid per four-year period. Binaural aids are covered under specific circumstances. Hearing aid batteries, insurance and ear molds are also covered.

Note: These services are covered when medically necessary. Other terms, conditions and/or limitations may apply.

Services included under Turquoise Care — There is no cost share for eligible services

Services	Coverage
High Fidelity Wraparound Services	Covered.
Home Health Services	Covered with limits.
Hospice Services	Covered.
Hospital Inpatient (including Detox Services)	Covered.
Hospital Outpatient	Covered.
Indian Health Services	Covered.
Inpatient Hospitalization in Freestanding Psychiatric Hospitals	Covered through age 21.
Institutions for Mental Disease (IMD) for SUD only	Covered.
Intensive Outpatient Program Services	Covered.
IV Outpatient Services	Covered.
Laboratory Services	Covered.
Medication Assisted Treatment for Opioid Dependence	Covered.
Midwife Services	Covered.
Multi-Systemic Therapy Services	Covered.
Non-Accredited Residential Treatment Centers and Group Homes	Covered.
Nursing Facility Services	Covered.
Nutritional Counseling	Covered for ABCB/SDCB only.

Note: These services are covered when medically necessary. Other terms, conditions and/or limitations may apply.

Services included under Turquoise Care — There is no cost share for eligible services

Services	Coverage
Nutritional Services	Covered.
Occupational Services	Covered.
Outpatient Health Care Professional Services	Covered.
Outpatient Hospital-Based Psychiatric Services and Partial Hospitalization	Covered.
Outpatient and Partial Hospitalization in Freestanding Psychiatric Hospital	Covered.
Peer Support Services	Covered.
Personal Care Services	Covered for ABCB only.
Pharmacy Services	Covered.
Physical Health Services	Covered.
Physical Therapy	Covered.
Physician Visits	Covered.
Podiatry Services	Covered.
Pregnancy Termination Procedures	Covered with limits.
Preventive Services	Covered.
Private Duty Nursing	Covered with limits.
Prosthetics and Orthotics	Covered.
Psychosocial Rehabilitation Services	Covered.
Radiology Facilities	Covered.

Note: These services are covered when medically necessary. Other terms, conditions and/or limitations may apply.

Services included under Turquoise Care — There is no cost share for eligible services

Services	Coverage
Recovery Services (Behavioral Health)	Covered.
Rehabilitation Option Services	Covered.
Rehabilitation Services Providers	Covered.
Related Goods	Covered.
Reproductive Health Services	Covered.
Respite (BH)	Covered with limits.
Rural Health Clinics Services	Covered.
School-Based Health Clinic Services	Covered.
Screening, Brief Intervention, Referral to Treatment (SBIRT) Services	Covered.
Specialized Therapies	Covered with limits.
Speech and Language Therapy	Covered.
Supportive Housing	Covered with limits.
Swing Bed Hospital Services	Covered.
Telehealth Services	Covered.
Tobacco Cessation Treatment and Services (may include counseling, prescription medications, and products)	Covered.
Tot-to-Teen Health Checks	Covered.
Transitional Care Management Services	Covered.

Note: These services are covered when medically necessary. Other terms, conditions and/or limitations may apply.

Services included under Turquoise Care — There is no cost share for eligible services

Services	Coverage
Transplant Services	Covered.
Transportation Services – Medical	Covered.
Treatment Foster Care I	Covered.
Treatment Foster Care II	Covered.
Vision Care Services	Covered every 12 months for those under 21 years of age. For those 21 and over, vision services are covered every 3 years.

Note: These services are covered when medically necessary. Other terms, conditions and/or limitations may apply.

Agency-based Community Benefit services — The following are included in addition to the services listed above — No cost share for eligible service

Services	Coverage
Adult Day Health	Covered.
Assisted Living	Covered under certain circumstances. Room and Board is not covered.
Behavior Support Consultation	Covered.
Community Transition Services	Covered.
Emergency Response	Covered.
Employment Supports	Covered.
Environmental Modifications	Covered. Up to a maximum of $5,000 per five-year period.
Home Health Aide	Covered.
Nutritional Counseling	Covered.
Personal Care Services (Consumer Directed and Consumer Delegated)	Covered.
Private Duty Nursing for Adults	Covered.
Respite	Covered with limits.
Skilled Maintenance Therapy Services	Covered.

Note: These services are covered when medically necessary. Other terms, conditions and/or limitations may apply.

Self-directed Community Benefit services included* — No cost share for eligible service

Services	Coverage
Behavior Support Consultation	Covered.
Customized Community Supports	Covered.
Emergency Response	Covered.
Employment Supports	Covered.
Environmental Modifications	Covered ($5,000 limit every 5 years).
Home Health Aide	Covered.
Nutritional Counseling	Covered.
Private Duty Nursing for Adults	Covered.
Related Goods	Covered; including fees and memberships; technology for safety and independence; cell or landline phone and related equipment; internet service; fax machine; computer; office supplies; printer; health-related equipment and supplies; exercise equipment and related items; nutritional supplements; over-the-counter medication; household-related goods; appliances for independence; adaptive furniture.
Respite	Covered with limits.
Self-Directed Personal Care	Covered.
Skilled Maintenance Therapy Services	Covered.

Note: These services are covered when medically necessary. Other terms, conditions and/or limitations may apply.

Self-directed Community Benefit services included* — No cost share for eligible service

Services	Coverage
Specialized Therapies	Covered with limits.
Start-Up Goods	Covered (for member electing SDCB on or after January 1, 2019, one-time limit of $2000).
Transportation (non-medical)	Covered with limits.
Trauma-Focused Cognitive Behavioral Therapy (TFCBT)	Covered.

*** Self-directed budget and services are limited based on medical necessity and budget.**

Note: These services are covered when medically necessary. Other terms, conditions and/or limitations may apply.

Hearing

If you are experiencing hearing loss or hearing aid difficulties, please contact Member Services at **1-877-236-0826**, TTY **711**. Certain services are available if you do have a hearing impairment and need a special telephone. Contact your Care Coordinator who will help you get special equipment if you need it.

Behavioral health

As a UnitedHealthcare Community Plan member, you are eligible for Behavioral Health Services. These can help you with personal problems that may affect you or your family. These include stress, depression, anxiety, a gambling problem, or using drugs or alcohol. Members may self-refer to Behavioral Health providers for services.

If you are currently receiving behavioral health services, please let your UnitedHealthcare Community Plan Care Coordinator know. It is important for them to be aware of all the services you are receiving or need.

Also, please let your behavioral health provider know that you are enrolled in UnitedHealthcare Community Plan's Turquoise Care program. They may have questions about the services you are receiving through Turquoise Care and how we can work together to help you get the care you need.

Behavioral Health screenings are performed as medically necessary for diagnosis and treatment.

988 Crisis Line

The 988 Suicide and Crisis Lifeline, previously known as the National Suicide Prevention Lifeline, offers 24/7 call, text and chat access to trained crisis counselors who can help people experiencing suicidal, substance use, and/or mental health crisis, or any other kind of emotional distress. People can also call, text or chat 988 if they are worried about a loved one who may need crisis support.

The 988 Lifeline is a direct connection to immediate support and resources for anyone in crisis. Dial 988 or **https://988lifeline.org/**.

There are three ways you can find a behavioral health provider who is in our network.

1. Search online at **myuhc.com/communityplan/nm**.
2. Look through the Provider Directory.
3. Call Member Services at **1-877-236-0826** and talk to a Member Advocate or your Care Coordinator.

Dental

Do I have dental benefits?
UnitedHealthcare Community Plan of New Mexico Turquoise Care Medicaid Dental manages your dental benefits. You may call Member Services at **1-877-236-0826** to find a dentist in the UnitedHealthcare Community Plan New Mexico network.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

What are EPSDT services?
The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children age 1–20 who are enrolled in Medicaid. Follow the EPSDT schedule for all eligible UnitedHealthcare Community Plan members up to age 20, including pregnant members. EPSDT screening including the following:

- Immunizations
- Oral health fluoride varnish and supplementation
- Hearing screening
- Vision screening
- Medical history
- Measurements of height, weight and BMI
- Unclothed physical examination

- Nutrition screening
- Developmental/Behavioral assessment
- Hematocrit/Hemoglobin at 9 months and 13 years
- Lead screening at 12 months and 24 months
- Standardized developmental screening
- Additional screening necessary according to risk factors
- Anticipatory guidance

These exams may include vaccinations or shots. If your child has not had his or her checkup this year, call the doctor and schedule one. We may send you a reminder letter to get your child checked.

Lead testing — The doctor will need to do a blood test to make sure your child does not have too much lead. Your child should be checked at 12 months and 24 months of age or if they have never been checked.

Dental exam — Your child should have their teeth cleaned and receive fluoride treatments every six months.

Private duty nursing — When your child's doctor wants a nurse to provide care at home or at school.

Personal care services — When your child's doctor wants a caregiver to help your child with eating, bathing, dressing and toileting.

EPSDT also provides hearing services, vision services, school-based services and more. If you have questions, please contact your Care Coordinator.

Health problems should be identified and treated as early as possible. If your child needs special services like Private Duty Nursing or Personal Care Services, they will be provided under EPSDT through UnitedHealthcare Community Plan.

Please speak with your doctor about any shots your child may need.

Vision

What if I need an eye exam or glasses?
March Vision manages your vision benefit. You may call Member Services at **1-877-236-0826** or visit their website at **www.marchvisioncare.com** to find a vision provider.

Long Term Services and Supports

Our New Mexico Long Term Services and Supports (LTSS) is a health coverage program for New Mexico residents who meet requirements and who are eligible for Medicaid. LTSS is designed to improve quality of life for members of any age who have functional limitations and/or chronic illnesses. LTSS helps support the member to live or work in the setting of their choice, which may include the person's home, a worksite, provider-owned or controlled residential setting, a nursing facility, or other institutional setting. LTSS provides in-home counseling sessions that focus on solving problems and becoming socially and physically active.

Community Benefit

What is the Community Benefit?

1. **The Community Benefit (CB) is Turquoise Care's name for the home and community-based services (HCBS) benefit package.**
   - The Personal Care Services benefit is also part of CB
   - Community Benefits are services that allow eligible members to receive care in their home or community as an alternative to being placed in a long-term care facility
   - Community Benefits are intended to supplement natural supports and support community living
2. **Goals of Community Benefits.**
   - Allow New Mexicans who require long-term care to remain in their homes and in their communities
   - Reduce the number of unnecessary nursing home admissions
3. **Community Benefit eligibility.**
   - All members must have a full Medicaid category or have Waiver category of eligibility
   - All members must meet the nursing facility level-of-care criteria
   - All members must be a New Mexico resident
4. **Community Benefit options choices.**
   - **Agency-Based Community Benefit (ABCB)** — Members work with their care coordinator to develop a care plan and select a community provider in the MCO network. The member's MCO ensures payment to Community Benefit providers.
   - **Self-Directed Community Benefit (SDCB)** — Members work with a support broker, develop a care plan, select their own vendors and authorize timesheets and ensure payment to their vendors
   - Vendors/employees and the Employer of Record will authorize timesheets to ensure payment

 Questions? Visit **myuhc.com/communityplan/nm**, or call Member Services at **1-877-236-0826**,TTY **711**.

- All members who meet eligibility requirements must participate in the ABCB for at least 120 days before they can switch to SDCB. (*Please refer to SDCB section for more details on this option.)

Agency-Based Community Benefit

1. **ABCB enrollment.**
   - If a member needs or wants long-term care, the member must contact Member Services and request Community Benefits. ABCB is not a 24-hour service for care. A Care Coordinator will complete an assessment with the member to determine if the member is eligible to receive these services. If a member is determined to be financially and medically eligible to receive services listed under the ABCB benefit package, a Comprehensive Care Plan (CCP) will be developed identifying the member services.
2. **ABCB benefit package:**
   - Assisted living under certain circumstances
   - Adult day health
   - Behavior support consultation
   - Community transition services
   - Emergency response
   - Employment supports
   - Environmental modifications
   - Home health aide
   - In-home services
   - Personal care
   - Private duty nursing for adults
   - Respite
   - Skilled maintenance therapy for adults
3. **ABCB provider network.**
   - Members must check with their Turquoise Care MCO for an in-network Community Benefit provider list. All ABCB providers must be enrolled as an Active Medicaid Provider Type 363 and have an HCA/MAD approval to provide the listed service.

Self-Directed Community Benefit

1. **What is the Self-Directed Community Benefit?**
   - The Self-Directed Community Benefit (SDCB) is Turquoise Care's name for the home and community-based services (HCBS) benefit package that allows eligible members to direct their own care and services
     - SDCB members may choose who provides their services and how they are provided
     - SDCB members may purchase goods that enable them to be more independent
     - SDCB members authorize and submit timesheets and invoices for payment
     - SDCB members are an employer of record to ensure payment to employees and vendors

- Self-Directed Community Benefits are services and goods that allow eligible members to receive care in their home or community as an alternative to being placed in a long-term facility
- Community Benefits are intended to supplement natural supports and are not intended to provide 24-hour care to the member
- Turquoise Care members must receive Community Benefits in the Agency-Based Community Benefit (ABCB) for at least 120 calendar days before they can switch to the SDCB program

2. **As a Turquoise Care SDCB member, you are responsible for directing your own care.**
   - Every SDCB member is in charge of what types of services and goods best meets their individual needs
   - The SDCB member has an Employer of Record (EOR) who manages the payment of their providers. The EOR can be the SDCB member or another individual of the member's choosing. Medicaid does not allow the EOR to be paid to perform the EOR duties.
   - The EOR hires and fires the employees and vendors who provide the type of care needed to maintain the SDCB member's health and safety
   - The EOR makes sure the SDCB member's employee timesheets and invoices are accurate, signed and submitted to the FMA on time
   - The EOR cannot be a paid employee for the SDCB member
3. **Every Turquoise Care SDCB member works with a care coordinator and a support broker.**
   - The SDCB member works with a support broker, similar to a Mi Via consultant. The support broker helps the member build an SDCB care plan and assists the member with the SDCB program.
   - All MCOs contract with support brokers. All SDCB members must choose a support broker that is contracted with their selected MCO.
   - SDCB members also have an MCO care coordinator who helps the SDCB support broker manage the member's SDCB program
   - The care coordinator and support broker assist the SDCB member with virtually every aspect of the SDCB
4. **Every Turquoise Care SDCB member works with the Financial Management Agency (FMA) who credentials their employees and processes provider payroll.**
   - The FMA manages an online system to allow SDCB members to view their approved SDCB care plan and their budget expenditures
   - All SDCB members work with the same FMA to perform the financial tasks associated with hiring, firing and paying providers on time

5. **The SDCB budget is determined based on the SDCB member's needs.**
   - SDCB budgets are determined by the types of services an SDCB member is assessed to need. The Care Coordinator completes a Comprehensive Needs Assessment (CNA) when the Level of Care is determined or redetermined.
   - The CNA identifies the services that will help the SDCB member stay safe in the community, and a Medicaid dollar amount is assigned to these services. The SDCB care plan is built using the approved SDCB budget. The support broker helps the member build the SDCB care plan which covers the SDCB member's needs for a year.
   - The MCO reviews the proposed SDCB care plan and makes the final approval and/or denial
6. **An SDCB member's family may be a provider if qualified and approved to work.**
   - An SDCB member may submit a written request to their MCO to hire a family member
   - The MCO will determine if the member meets the criteria to have a family member get paid to provide their care
7. **An SDCB member may transition to the ABCB model at any time.**
   - If an SDCB member no longer wishes to direct their own care, the member may request to leave the SDCB program and get his or her services from the ABCB
   - There is no break in service during this transition; however, there are different services available in each Community Benefits benefit package
     - For example, related goods are not available in ABCB, and Assisted Living is not available in SDCB
   - The MCO may request an SDCB member transition to the ABCB if the member is having difficulty managing the SDCB program. Extensive education and assistance is provided to the member to help them understand the SDCB program prior to making the decision to transition them to the ABCB model.

Community transition

What if I live in a nursing home and want to move out?
We want to help you live in the place that is right for you. Talk to your Care Coordinator about your options if you are thinking about moving. You can talk to your Care Coordinator by calling **1-877-236-0826**.

Transportation

UnitedHealthcare offers transportation to medical, dental, vision and behavioral health appointments.

Out-of-plan benefits

What services are NOT included in the Turquoise Care benefit package?

- Acupuncture services*
- Cosmetic services
- In vitro services
- Inpatient facility room and board — leave of absence
- Routine podiatry services
- Services to intermediate care facilities for the intellectual disability

Services covered under other programs:

- Children, Youth and Families Department case management, defined as Child Protective Services and Juvenile Probation and Parole Officers case management
- Case management provided by the Aging and Long-Term Service department
- Services in the schools and in the Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP) for children under age 20
- Home and Community-Based Waiver Services for the Medically Fragile Waiver, the HIV/AIDS Waiver, and the Developmentally Disabled Waiver

Community Health Plan – Value Added Services (VAS)

These extra benefits are in addition to your Turquoise Care benefits.

In addition to of your regular Turquoise Care benefits, you may also be eligible for these services from UnitedHealthcare Community Plan. Limits apply, see below. There is no cost for eligible members.

You should work with your Care Coordinator or call Member Services for assistance in accessing VAS at **1- 877-236-0826**, TTY **711**.

Value added service	Population served	Exclusions	Prior authorization required?	Limits
Babyscripts A digital maternity engagement, education and incentive program for members who are pregnant and new parents. The app includes daily educational content on healthy behaviors, the baby's development, vaccinations, potential health risks and many other topics. There are in- depth resources on nutrition, exercise, labor and delivery, breast-feeding and more. The app provides appointment reminders and risk assessments in English and Spanish. Health assessment data collected via the app will feed into care management platforms to support member stratification, care pathway creation and engagement.	Prenatal, Postpartum and members parenting children	Program ends at 12 months post delivery	No	None

Value added service	Population served	Exclusions	Prior authorization required?	Limits
Behavioral Health Substance Use Disorder (SUD) Helpline is an anonymous, confidential, payer- agnostic helpline where community members and their families or friends can call and speak with a licensed behavioral health expert for information on SUD treatment. Members can work with a licensed clinician to plan the next step in their care should they choose to pursue treatment.	All members	None	No	None

Value added service	Population served	Exclusions	Prior authorization required?	Limits
Behavioral Health Programming Our online behavioral health resources connect members to information and resources for overall health and wellness, including specific behavioral health tools, resources and information. For example, our health and wellness library feature 60 centers and over 220 videos focused on topics such as physical health, mental health, substance use, recovery tools, resiliency skills development, caregiving, parenting, supports for Native Americans, school and education, suicide prevention, mindfulness and disaster planning and recovery that combine resources (e.g., articles, videos, training programs, screeners).	All members	Members need to register through our website to access the resources.	No	None
Car Seat Program Provides Car Seat to Pregnant members for safe infant car seat	Prenatal, Postpartum and members parenting children	None	No	One Car Seat per infant per delivery

Value added service	Population served	Exclusions	Prior authorization required?	Limits
Clothing Allowance for School Aged Children Provides allowance for clothing through Community partners.	Children	None	Yes	$100 per child
Electroconvulsive Therapy Electroconvulsive Therapy is a medical treatment for severe mental illness in which a small, carefully controlled amount of electricity is introduced into the brain and is used to treat a variety of psychiatric disorders, including severe depression.	All members (Court order is required for children under 14.) UHCCP will follow BHSD LOC guidelines and NM Statute.	Requires evaluation and Assessment by psychiatric provider	Yes	None
Emissar Youth Provides a method of digitally delivered peer support between youth peer support specialists and transition aged youth/ foster-adoptive members. This platform is designed for youth peer support specialists to provide one (1) hour in-person or virtual weekly meetings and bridge the gap between regular meetings by providing text message peer support via the mobile application.	Justice Involved Individuals (Youth)	Requires access to smartphone and access to broadband to access resource	No	None

Value added service	Population served	Exclusions	Prior authorization required?	Limits
Enhanced Diet and Nutritional Counseling Dietary counseling for any UHC member with any network provider	All members	No medical diagnosis required	No	None
Health and Hypoallergenic Pillow and Mattress Covers Reduce and prevent allergic reactions. Increase opportunity to participate in sports and other health-promoting activities; decrease ER visits	This fund is for Children and Adolescents between the ages of 3–21 years of age, with a diagnosis of either Asthma and/or Allergies.		Yes	Two pillow covers and one mattress cover per year
Health and Wellness/Fitness Acupuncture	All members	Limited to 5 visits per year	No	$75 per visit
Legal/Justice An online support program available to all children and youth who are transitioning out of the justice system or transitioning to independent living.	Justice Involved Individuals (Youth)	None	No	None

Value added service	Population served	Exclusions	Prior authorization required?	Limits
Medically Tailored and Culturally Appropriate Meals Home-delivered, medically tailored, culturally appropriate meals to promote better health and support health care. Meals can be tailored for members with regular and specialty dietary needs, and can support puréed, gluten free and vegetarian. This program promotes healthy nutrition and addresses food insecurity or malnutrition. Focus supporting members through transitions of care, including: • Post-delivery, for member and up to four household members • Post-release meals for justice- involved members • Skilled nursing facility (SNF) transition, focused on LTSS members	All members	Post-delivery: two meals a day for 14 days, for member and up to four household members Post-release meals for justice-involved members: two meals a day for 14 days SNF transition, focused on LTSS members: two meals a day for 14 days Community Partner referred members that need food assistance	Yes	None

Value added service	Population served	Exclusions	Prior authorization required?	Limits
OnePass One Pass™ is a total physical, mental, and social well-being solution for adults 18 and older, providing access at no additional cost to gyms and fitness locations, including leading national brands, independent gyms, and boutique studios. As well as on-demand and livestreaming digital content, brain training, and social activities designed around you and your goals and lifestyle. Includes YMCA.	All members	Requires member code	No	None

Value added service	Population served	Exclusions	Prior authorization required?	Limits
PEARLS – Program to Encourage Active, Rewarding Lives Peer Support A treatment program developed by the University of Washington designed to reduce symptoms of depression and improve quality of life among older adults and all-age adults with epilepsy. The program consists of six to eight in-home counseling sessions that focus on the following goals: solving problems, becoming socially and physically active and scheduling enjoyable activities. We will train and use certified provider- based peers to deliver this service.	Seniors and members with LTSS Tribal members	Sufficient resources to provide training across the state	No	Six to eight in-home counseling sessions

Value added service	Population served	Exclusions	Prior authorization required?	Limits
SDOH Flex Fund (Emergency Fund) Assistance for non-medical needs that support barriers to vital services required to survive such as Housing and associated costs to remain in housing, Food Assistance, Transportation, gasoline vouchers and clothing vouchers are some examples	All members	Requests are evaluated and funds disabused on a case by case basis	Yes	TBD Case by Case

Value added service	Population served	Exclusions	Prior authorization required?	Limits
Seeking Safety Seeking Safety is designed to help people who have experienced trauma or substance problems develop and sustain recovery goals. Seeking Safety encourages ones who have suffered trauma to find a safe environment to engage with their peers, respect themselves and develop and use healthy coping techniques to achieve their recovery goals. We are the only managed care entity approved by Seeking Safety's creator to train and use certified provider-based peers to render this program.	Individuals dealing with a trauma background and addictive or impulsive behavior can benefit from this program.	None	No	None

Value added service	Population served	Exclusions	Prior authorization required?	Limits
SeniorLink Assist unpaid and family caregivers by providing support services that focus on engaging, empowering, educating and supporting caregivers. Seniorlink coaches design a person-centered program for each member after completing an assessment that evaluates the knowledge, skills and needs of the caregiver and the member's health risks and behavioral challenges. Through this person-centered program, Seniorlink builds a care plan specific to unpaid and family caregivers to make sure they have the tools and resources to support members in their homes by supporting their families.	Seniors and members with LTSS Senior Tribal members	Requires evaluation and approval. Eligibility determined on individual basis	Yes	None

Value added service	Population served	Exclusions	Prior authorization required?	Limits
SeniorLink (continued from previous page) To support all caregivers, especially those in disenfranchised populations, such as those on tribal lands, Seniorlink has invested in developing cultural competency among their care teams in topics such as history, demographics, socioeconomics, government, family relationships, belief systems, verbal and nonverbal communication styles, rural versus urban differences, health care practices and implementation strategies in the Native American community.	Seniors and members with LTSS Senior Tribal members	Requires evaluation and approval. Eligibility determined on individual basis	Yes	None

Value added service	Population served	Exclusions	Prior authorization required?	Limits
Senior.One Comprehensive care navigation services have been tailored to enhance the healthcare journey for Members enrolled in the Long-Term Services and Supports (LTSS) programs. The mission is to streamline the care navigation process, to ensuring that every senior receives the personalized care and support they deserve.	Seniors and members with LTSS	None	No	None

Value added service	Population served	Exclusions	Prior authorization required?	Limits
Technology SelfCare is a self-help digital application that uses cognitive behavioral therapy- based tools and techniques to improve overall mental well-being and behavioral health tracking, supporting members before they are in crisis. Self Care is designed to enable resilience by helping members build new skills and daily habits. Features include self-paced digital programs available on demand, any time; industry-recognized clinical depression, anxiety and well- being surveys; and evidence-informed mental health support through trackers, mental health skills and tools collections and communities, all offered in both English and Spanish. With a 97% member satisfaction rating, Self Care provides digital support for members who may not be ready for traditional treatment.	All members	None	No	None

Value added service	Population served	Exclusions	Prior authorization required?	Limits
Technology Enable members to connect to their providers virtually, via phones (through LifeLine), data plans, home-based internet and remote patient monitoring device.	All members	Limited up to $250 per member	No	$50 per month
Traditional/Alternative Treatments Supports member preference for alternative healing supports and provides resources to promote person-centered care and maintenance of general health. We will provide a $300 annual reimbursement for Native American members and for traditional or healing practices.	Native Americans	18+	No	$300 per year

Value added service	Population served	Exclusions	Prior authorization required?	Limits
TripMaster Transportation service to nonmedical community services such as Women, Infants and Children (WIC) services, birthing classes, place of worship, grocery store, job- related activities, food pantry and support group meetings. UnitedHealthcare will allow family members or their caregivers to accompany members to their appointment, with three-day prior preapproval.	All members	Limited to 20 one-way or 10 round trips per year Rides to/from venues such as liquor stores, casinos, bars, horse tracks are not permitted Travel mileage limited to 75 miles radius	No Transport must be scheduled with Member Services	$1000 per year

Value added service	Population served	Exclusions	Prior authorization required?	Limits
Virtual Doula and Lactation Services Virtual Maternal Health Solution, offers 24 hours a day, seven days a week, on-demand access to doulas and lactation consultants to address members' acute needs, concerns and questions about their perinatal journey and baby's health. Galileo supports the perinatal journey by offering routine prenatal care in coordination with local providers for testing, ultrasound and other services requiring in-person care; tracking and management of appropriate screens and tests; early identification, management and referral of high-risk pregnancies; and integrated behavioral health screening and referrals. Galileo's focus on whole person care includes prioritizing SDOH screening and referrals to community supports, which further enhance the resources available to our pregnant and parenting members.	Prenatal, Postpartum and members parenting children	None	Yes	One year

Value added service	Population served	Exclusions	Prior authorization required?	Limits
Virtual Doula and Lactation Services (continued from previous page) All of Galileo's services are available in Spanish and English. Members who set their preference to Spanish will receive the full Spanish experience (not English translated to Spanish).	Prenatal, Postpartum and members parenting children	None	Yes	One year
Dental ACC/Fluoride Varnishing Treatment	All members	One per Lifetime	No	None
Dental Fluoride Treatment	All members	Treatment every six months.	No	None
Vision Refractive Eye Exam	All members	Once every 24 month	No	None

Value added service	Population served	Exclusions	Prior authorization required?	Limits
Women/Infant Wellhop is a virtual support group for members who are pregnant. The program includes the following: • Group video conversations with a trained facilitator and members at the same stage in Pregnancy • Evidence- based information on pregnancy and postpartum, educational articles, videos, podcasts and more • Convenient access from mobile devices Access to online community 24 hours a day, seven days a week	Prenatal, Postpartum and members parenting children	None	No	None
Workforce Fund Provides scholarships/ funding to members seeking to obtain certificate, degree or workforce programs	All members	Requires program enrollment information	Yes	Up to $1500 per member

Alternative Benefit Package (ABP) benefits covered by UnitedHealthcare Community Plan

The table below offers a comparison of the ABP services package to the services that are covered under Standard Medicaid. Since individuals who have ABP coverage will always be ages 19–64, the comparison to Standard Medicaid coverage is for the same age range (ages 19 and above).

Members between 0–20 essentially get full benefits via the EPSDT benefit.

Benefit category and service	ABP coverage (recipients ages 19–64)	Standard Medicaid coverage (for ages 19 and above)
Outpatient services		
Acupuncture	Not covered.	Covered.
Cancer clinical trials	Covered with Prior Authorization.	Covered with Prior Authorization.
Chiropractic services	Covered.	Covered.
Dental services • Diagnostic dental • Dental radiology • Preventive dental • Restorative dental • Prosthodontics (removable) • Oral surgery • Endodontic services for anterior teeth	Covered. Preventive dental services are covered based on a periodicity schedule.	Covered.
Dialysis	Covered.	Covered.

Benefit category and service	ABP coverage (recipients ages 19–64)	Standard Medicaid coverage (for ages 19 and above)
Outpatient services (continued)		
Hearing aids and hearing aid testing	Not covered, except for recipients age 19–20. See page 103 **ABP Exempt** for possible coverage for eligible members.	Covered.
Holter monitors and cardiac event monitors	Covered.	Covered.
Home health care and intravenous services	Covered when medically necessary. Home health care is limited to 100 four-hour visits per year. See page 103 **ABP Exempt** for possible coverage for eligible members.	Covered when medically necessary. No limitation on number of visits.
Hospice care services	Covered.	Covered.
Non-emergency medical transportation	Covered.	Covered.
Outpatient diagnostic labs, X-ray and pathology	Covered.	Covered.
Outpatient surgery	Covered.	Covered.
Primary care to treat illness/injury	Covered.	Covered.
Radiation and chemotherapy	Covered.	Covered.

Benefit category and service	ABP coverage (recipients ages 19–64)	Standard Medicaid coverage (for ages 19 and above)
Outpatient services (continued)		
Special medical foods for inborn errors of metabolism	Not covered, except for recipients age 19–20 when medically necessary.	Covered for recipients age 19–20 only when medically necessary.
Specialist visits	Covered.	Covered.
Telemedicine services	Covered.	Covered.
Treatment of diabetes	Covered.	Covered.
Vision care for eye injury or disease	Covered. Vision refraction is also covered.	Covered. Standard Medicaid covers vision refraction and routine vision services.
Vision care – Routine (refraction, frames and lenses)	Covered for members with eye injury or disease. Not covered for members without eye injury or disease. Refraction for visual acuity in routine vision care is covered for members ages 19–20.	Covered, no age limitation.
Vision hardware (eyeglasses or contact lenses)	Covered only following the removal of the lens from one or both eyes (aphakia). Coverage of materials is limited to one set of contact lenses or eyeglasses per surgery, within 90 days following surgery. Vision hardware and routine vision care are covered for recipients ages 19–20 following a periodicity schedule.	Covered. Contact lenses require prior authorization.

Benefit category and service	ABP coverage (recipients ages 19–64)	Standard Medicaid coverage (for ages 19 and above)
Emergency services		
Emergency department services/facilities	Covered.	Covered.
Emergency ground or air ambulance services	Covered.	Covered.
Urgent care services/facilities	Covered.	Covered.
Hospitalization		
Bariatric surgery	Covered. Limited to one per lifetime and when medically necessary. See page 103 **ABP Exempt** for possible coverage for eligible members.	Covered. No limitation on number of surgeries, as long as medical necessity is met.
Inpatient medical and surgical care	Covered.	Covered.
Organ and tissue transplants	Covered. Limited to two per lifetime. See page 103 **ABP Exempt** for possible coverage for eligible members.	Covered. No limitation on number of transplants, as long as medical necessity is met.
Reconstructive surgery for the correction of disorders that result from accidental injury, congenital defects or disease	Covered.	Covered.

Benefit category and service	ABP coverage (recipients ages 19–64)	Standard Medicaid coverage (for ages 19 and above)
Maternity care		
Birthing options program	Covered.	Covered.
Delivery and inpatient maternity services	Covered.	Covered.
Pre- and postnatal care	Covered.	Covered.
Mental/behavioral health and substance use disorder services		
Assertive Community Treatment (ACT)	Covered.	Covered.
Behavioral health supportive services (family support, recovery services, respite services)	Covered.	Covered.
Electroconvulsive Therapy (ECT)	Covered.	Covered.
Inpatient hospital services in a psychiatric unit of a general hospital, including inpatient substance abuse detoxification	Covered.	Covered.
Medication-assisted therapy for opioid addiction	Covered.	Covered.
Outpatient behavioral health professional services (includes evaluation, testing, assessment, medication management and therapy)	Covered.	Covered.

Benefit category and service	ABP coverage (recipients ages 19–64)	Standard Medicaid coverage (for ages 19 and above)
Mental/behavioral health and substance use disorder services (continued)		
Outpatient services for alcoholism and drug dependency, including Intensive Outpatient Program (IOP)	Covered.	Covered.
Psychosocial Rehabilitation (PSR)	Covered.	Covered.
Medications		
Prescription medicines	Covered.	Covered.
Over-the-counter medicines	Coverage limited to prenatal drug items, and low-dose aspirin as preventive for cardiac conditions. Other OTC items may be considered for coverage only when the item is considered more medically or economically appropriate than the prescription drugs, contraceptive drugs, and devices and items for treating diabetes.	Covered. Some limitations apply.
Rehabilitative and habilitative services and devices		
Autism spectrum disorder	Covered for recipients age 19 or younger; or age 21 or younger when enrolled in high school. Includes physical, occupational and speech therapy, and applied behavioral analysis.	Coverage ends at age 20.

Benefit category and service	ABP coverage (recipients ages 19–64)	Standard Medicaid coverage (for ages 19 and above)
Rehabilitative and habilitative services and devices (continued)		
Cardiovascular rehabilitation	Covered. Limited to 36 visits per cardiac event.	Covered. No limitation on visits as long as medical necessity is met.
Durable medical equipment (DME), medical supplies, orthotic appliances and prosthetic devices, including repair or replacement	Covered. Requires a provider's prescription. DME is limited to a periodicity schedule and must be medically necessary. Disposable medical supplies are limited to diabetic and contraceptive supplies. Foot orthotics including shoes and arch supports are only covered when an integral part of a leg brace, or are diabetic shoes.	Covered. Most medically necessary disposable medical supplies are also covered when prescribed by a practitioner.
Disposable medical supplies — such as diapers, under pads, gauzes, gloves, dressings, colostomy supplies, for use at home by a recipient	Not covered except for diabetic supplies (reagents, test strips, needles, test tapes, alcohol swabs, etc.) and supplies necessary to utilize oxygen or DME such as administer oxygen, use nebulizer, clean tracheas for ventilator use, or assist in treatments such as casts or splints are covered.	Covered. Most medically necessary disposable medical supplies are also covered when prescribed by a practitioner.

Benefit category and service	ABP coverage (recipients ages 19–64)	Standard Medicaid coverage (for ages 19 and above)
Rehabilitative and habilitative services and devices (continued)		
Inpatient rehabilitative facilities	Covered. Skilled nursing or acute rehabilitation facility.	Covered.
Internal prosthetics	Covered.	Covered.
Physical, speech and occupational therapy (rehabilitative and habilitative services)	Covered. Short-term therapy limited to two consecutive months per condition. Long-term therapies are not covered.	Rehabilitative services covered. No limitation on duration of therapy as long as medical necessity is met. Habilitative services are not covered.
Pulmonary therapy	Covered. Limited to 36 visits per year.	Covered. No limitation on duration of therapy as long as medical necessity is met.
Skilled nursing	Covered primarily through home health agencies; subject to home health benefit limitations (100 four-hour visits per year). See page 103 **ABP Exempt** for possible coverage for eligible members.	Covered through home health agencies. No limitation on number of visits as long as medical necessity is met.
Laboratory and radiology services		
Diagnostic imaging	Covered.	Covered.
Lab tests, X-ray services and pathology	Covered.	Covered.

Benefit category and service	ABP coverage (recipients ages 19–64)	Standard Medicaid coverage (for ages 19 and above)
Preventive and wellness services and chronic disease management		
Allergy testing and injections	Covered.	Covered.
Annual consultation to discuss lifestyle and behavior that promote health and well-being	Covered.	Covered for age 19–20.
Annual physical exam	Covered.	Periodic physical exams are only covered for age 19–20. Additional annual physical exams may be provided through UnitedHealthcare Community Plan. Vision services, including refractions, eyeglasses and contact lenses, are covered but are limited to a set periodicity schedule.
Chronic disease management	Covered through primary care provider services.	Covered through primary care provider services.
Diabetes equipment, supplies and education	Covered.	Covered.
Genetic evaluation and testing	Covered. Triple serum test and genetic testing for the diagnosis or treatment of a current illness.	Covered.
Immunizations	Covered.	Covered.
Insertion and/or removal of contraceptive devices	Covered.	Covered.

Benefit category and service	ABP coverage (recipients ages 19–64)	Standard Medicaid coverage (for ages 19 and above)
Preventive and wellness services and chronic disease management (continued)		
Nutritional evaluations and counseling	Covered. Dietary evaluation and counseling as medical management of a documented disease, including obesity.	Not covered, except for age 19–20 and during pregnancy. Additional benefits may be available when provided through UnitedHealthcare Community Plan.
Osteoporosis diagnosis, treatment and management	Covered.	Covered.
Periodic colorectal examination (age 50–75)	Covered.	Covered.
Periodic glaucoma eye test (age 35 or older)	Covered.	Covered.
Periodic mammograms (age 40 or older)	Covered.	Covered.
Periodic stool examination (age 50–75)	Covered.	Covered only when medically indicated.
Periodic test to determine blood hemoglobin, blood pressure, blood glucose level and blood cholesterol level or a fractionated cholesterol level	Covered.	Covered.
Podiatry and routine foot care	Covered when medically necessary.	Covered.

Benefit category and service	ABP coverage (recipients ages 19–64)	Standard Medicaid coverage (for ages 19 and above)
Preventive and wellness services and chronic disease management (continued)		
Preventive care	Covered. Includes U.S. Preventive Services Task Force "A" and "B" recommendations; preventive care and screening recommendations of the HRSA Bright Futures program; and preventive services for women recommended by the Institutes of Medicine.	Coverage is limited. Many screening services are covered when appropriate based on age or family history.
Screening Pap tests (age 21–65)	Covered.	Covered.
Sleep studies	Covered for diagnosis.	Covered.
Smoking cessation treatment	Covered. Diagnosis, counseling and prescription medicines.	Covered only for recipients age 20 and under, and for pregnant women.
Voluntary family planning services	Covered.	Covered. (Same as ABP)
Weight loss programs	Not covered.	Not covered.
Long-term services and supports		
Community Benefits	Not covered. See page 103 **ABP Exempt** for possible coverage for eligible members.	Covered for those members meeting NFLOC.

Benefit category and service	ABP coverage (recipients ages 19–64)	Standard Medicaid coverage (for ages 19 and above)
Long-term services and supports (continued)		
Nursing facility care	Not covered, except as a step down level of care from a hospital prior to being discharged to home when skilled nursing services on a short-term basis are medically necessary.	Covered when the requirements to access these services are met, including nursing facility level of care (NF LOC) criteria.
Transportation	Covered.	Covered.

Disease and care management

If you have a chronic health condition like asthma or diabetes, UnitedHealthcare Community Plan has a program to help you live with your condition and improve the quality of your life. These programs are voluntary and available to you. The programs give you important information about your health condition, medications, treatments and the importance of follow-up visits with your physician. Chronic conditions that are targeted are: Childhood asthma, Diabetes, COPD (emphysema), and Depression.

A team of registered nurses and social workers will work with you, your family, your PCP, other health care providers and community resources to design a plan of care to meet your needs in the most appropriate setting. They can also help you with other things like weight loss, stopping smoking, making appointments with your doctor and reminding you about special tests that you might need.

You or your doctor can call us to ask if our care management or disease management programs could help you. If you or your doctor thinks a Care Manager could help you, or if you want more information about our care management or disease management programs, call us at **1-800-672-2156** or **1-401-732-7373**.

Wellness programs

UnitedHealthcare Community Plan has many programs and tools to help keep you and your family healthy, including:

- Classes to help you quit smoking. If you are pregnant or under the age of 21, coaching and medications are available to help you quit smoking.
- Pregnancy care and parenting classes
- Nutrition classes
- Well-care reminders

Your provider may suggest one of these programs for you. If you want to know more, or to find a program near you, talk to your PCP or call Member Services at **1-877-236-0826**, TTY **711**.

For moms-to-be and children

What if I am pregnant?

Call your primary care provider. The name and phone number is on your ID card. If you need help, call Member Services.

Pregnancy

At UnitedHealthcare Community Plan, we want you to have a healthy pregnancy and a healthy baby. We want you and your baby to get all the care you both need. That's why we have a special program for you — and your baby.

Our maternal child health team will help you learn what to expect when you see your doctor and how to take care of your changing body. Here are some of the things we will help you learn about:

- Local resources
- You, your doctor
- Nutrition, weight, and well-being
- Fitness
- Sexual health
- Substance abuse
- Domestic violence

Having a baby?

When you think you are pregnant, call your local Department of Human Services (DHS) office and Member Services at **1-877-236-0826**, TTY **711**. This will help ensure you get all the services available to you.

Let us help you

If you are pregnant, or are thinking of getting pregnant, please let your Care Coordinator know by calling **1-877-236-0826**.

Birthing Options Program

Is the Birthing Options Program offered?

You can choose to have services provided in a birth center, in your home, or in the hospital by a midwife. Midwives must be Medicaid approved health care providers to participate in this program. Talk to your midwife about problems that may happen if you deliver your baby outside of a hospital.

If you choose to have birthing services outside of a hospital, you have the right and responsibility to:

- Receive an informed consent from the midwife about problems that may happen if you deliver your baby outside of a hospital and;

Neonatal services

We want your baby to be healthy. Sometimes care is needed after the baby is born. One of our specialized Care Coordinators will call you if your baby is in the Neonatal Intensive Care Unit (NICU). If your baby needs extra care, we are here for you.

Our NICU Care Coordinators have many years of experience. Your NICU Care Coordinator will:

- Answer questions about your delivery, and newborn care
- Give information to help you make decisions
- Work with the NICU facility to make sure you and your baby get the care you need
- Help you make a plan for bringing your baby home and for any home care needs
- Put you in touch with local resources and services
- Review your benefits to make sure you are using all the services you can

Early Periodic Screening, Diagnosis and Treatment (EPSDT)

The purpose of EPSDT is to find and treat health problems early so that children can have the best health and development possible. Covered services include well-child checkups, evaluations and treatments for behavioral health, occupational, physical or speech language therapy needs. EPSDT services are covered for all children and young adults under 21 years of age.

For any EPSDT service, the member needs an examination and prescription for the service from the provider. If you have questions, please call Member Services at **1-877-236-0826**, TTY **711**.

Other plan details

Finding a network provider

We make finding a network provider easy. To find a network provider or a pharmacy close to you:

Visit **myuhc.com/communityplan/nm** for the most up-do-date information. Click on "Find a Provider."

Call Member Services **1-877-236-0826**, TTY **711**. We can look up network providers for you. Or, if you'd like, we can send you a Provider Directory in the mail.

Provider Directory

You have a directory of providers available to you in your area. The directory lists addresses and phone numbers of our in-network providers.

Provider information changes often. Visit our website for the most up-to-date listing at **myuhc.com/communityplan/nm**. You can view or print the Provider Directory from the website, or click on "Find a Provider" to use our online searchable directory.

If you would like a printed copy of our directory, please call Customer Service at **1-877-236-0826**, TTY **711**, and we will mail one to you.

Interpreter services and language assistance

Many of our Member Services employees speak more than one language. If you can't connect with one who speaks your language, you can use an interpreter to help you speak with Member Services.

Many of our network providers also speak more than one language. If you see one who doesn't speak your language, you can use our interpreter or sign language services to help you during your appointment. Arrange for your interpreter services at least 72 hours before your appointment. Sign language services require two weeks' notice. This is at no cost to you.

You can also have any printed materials we send you either sent in a different language or translated for you. To arrange for interpreter, translation services or audio format, call Member Services at **1-877-236-0826**, TTY **711**.

Payment for services

Do I need to pay for services?

Most services are covered by Turquoise Care. Copays apply in some instances. The only time you pay is when a service is not covered by Turquoise Care or when you get non-emergency service without meeting rules on prior authorization. In these cases, the provider must talk to you first about payment. Even if you fail to pay, you can keep your Medicaid eligibility.

What if I am incorrectly overcharged?

If a member has been incorrectly overcharged copayments, the member has a right to be repaid by the provider. The HSD Income Support Division (ISD) determines eligibility for most categories of Medicaid. If the member household disagrees with the household income calculation, then the household may request a HSD fair hearing.

Members have a right to request from UnitedHealthcare Community Plan at any time, an accounting of his or her household's accrued copayment total(s). If the member disagrees with the MCO's accounting of accrued copayments, the member may file an appeal directly with UnitedHealthcare Community Plan Member Services.

What if I get a bill from my doctor?

If you get a bill from a provider:

- Ask why they are billing you
- Give them your Turquoise Care information

You do not have to pay bills that UnitedHealthcare Community Plan should pay.

Who do I call if I get a bill?

If you get a bill:

- Call Member Services at **1-877-236-0826**
- Be sure you have your bill when you call

What information will they need?

You need to tell us who sent the bill, the date of service, the amount and the provider's address and phone. You also need to give your name, ID number, and other information.

What if I have other insurance in addition to Turquoise Care?

You must report other health insurance to your local Income Support Division office. If your private insurance is canceled, you have new coverage, or have questions, call Member Services or your Care Coordinator. Having other insurance does not affect whether you qualify for Turquoise Care.

Copayments

Copayments (copays) are charges you may have to pay to get certain services not covered under the plan, but you cannot be denied a service if you cannot pay the copayment. Tell your provider if you cannot pay. Turquoise Care benefits are at no cost, no copay for members eligible at the time of service.

Member copayment obligation

When a copayment is assessed and charged, non-eligible members must make payment at the time of service or make arrangements with the provider to make payment at a later date. The provider or MCO may utilize whatever legal actions are available to collect these amounts.

The following copayments apply to these members:

CHIP (Children's Health Insurance Plan)

Copays for CHIP:

Age 0–5 FPL between 241–300%
Age 6–18 FPL between 191–240%

Benefit	Copay amount	Notes
Prescription Drugs – Preferred	No copay	See Preferred Drug List (PDL).
Prescription Drugs – Non-Preferred	No copay	When less expensive drug is available on the PDL. Psychotropic drug items are exempt.
Outpatient Visit	No copay	Includes doctor or other practitioner, dental, vision, therapy session, or behavioral health service session.
Hospital – Inpatient Admission	No copay	All admissions.
Hospital – Non-emergent use of Emergency Room	No copay	When emergency room is used for other than an emergency.

WDI (Working Disabled Individuals)

Copays for WDI:

Up to 250% FPL

Benefit	Copay amount	Notes
Prescription Drugs – Preferred	No copay	See Preferred Drug List (PDL).
Prescription Drugs – Non-Preferred	No copay	When less expensive drug is available on the PDL. Psychotropic drug items are exempt.
Outpatient Visit	No copay	Includes doctor or other practitioner, dental, vision, therapy session, or behavioral health service session.
Hospital – Inpatient Admission	No copay	All admissions.
Hospital – Non-emergent use of Emergency Room	No copay	When emergency room is used for other than an emergency.

ABP (Alternative Benefit Plan)

FPL > 100%

Benefit	Copay amount	Notes
Prescription Drugs – Preferred	No copay	See Preferred Drug List (PDL).
Prescription Drugs – Non-Preferred	No copay	When less expensive drug is available on the PDL. Psychotropic drug items are exempt.
Outpatient Visit	No copay	Includes doctor or other practitioner, dental, vision, therapy session, or behavioral health service session.
Hospital – Inpatient Admission	No copay	All admissions.
Hospital – Non-emergent use of Emergency Room	No copay	When emergency room is used for other than an emergency.

ABP Exempt

Adult Benefit Plan Exempt (ABP Exempt) means a member subject to coverage under the ABP and who has been determined as meeting the definition and criteria of Medically Frail or is otherwise exempt from mandatory enrollment in the ABP.

The following individuals are ABP Exempt and may voluntarily opt-out of the ABP:

- Individuals who qualify for medical assistance on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individuals are eligible for Supplemental Security Income benefits
- Individuals who are terminally ill and are receiving benefits for hospice care
- Pregnant individuals
- Individuals who are Medically Frail

Adult member who would be covered under the ABP but who has been determined as meeting HCA's definitions and criteria for the following conditions:

- Disabling mental disorder, including individuals up to age twenty-one (21) with serious emotional disturbances (SEDs) and adults with serious mental illness (SMI)
- A chronic substance use disorder
- A serious and complex medical condition as defined by HCA in Section 13 of the Managed Care Policy Manual
- A physical, intellectual, or developmental disability that significantly impairs the Member's ability to perform one (1) or more activities of daily living (ADL)
- A disability determination based on Social Security criteria

To learn more about the benefits of being ABP Exempt, the differences between ABP Exempt status and ABP, or to self-identify that you are exempt from mandatory enrollment into ABP, please call Member Services at **1-877-236-0826** (TTY **711** for the hearing impaired).

If you disagree with UnitedHealthcare's ABP Exempt status determination, you may use our appeals and grievance process to file an appeal and/or grievance regarding the decision. This process is explained on page 121.

Utilization Management (UM) decisions

The services you get are very important to us. We help you get the right care, at the right time, in the right setting. We don't want you to get too little care or care you don't need.

Only doctors and pharmacists decide what services are covered. These decisions are based on medical necessity. We do not reward our UM team for decisions they make about a member's care.

How to contact the UnitedHealthcare Community Plan Turquoise Care Utilization Management team

The UnitedHealthcare Community Plan Turquoise Care UM team is available Monday–Friday, 8:00 a.m.–5:00 p.m. to help you with utilization management and/or prior notification questions. You can reach the team by calling toll-free at **1-877-236-0826**. Assistance is available after-hours at the same telephone number.

Quality improvement program

The UnitedHealthcare Community Plan of New Mexico wants you to get the best care and service. That is why we have a Quality Management (QM) Program. Our QM program helps us to learn what we can do better. Then we use it to get better. You can request more information. Please call customer service at **1-877-236-0826**.

What if I want a second opinion?

You can get a second opinion for your health care from an in-network provider or, if one is not available, from an out-of-network provider at no cost to you. Call your primary care provider or your Care Coordinator. You can also call Member Services.

Special options for Native American members

Native American members may go to an Indian Health Service (IHS) or Tribal health care facility. There is no need for a referral or prior authorization.

Advance directives

An advance directive is a set of written steps you want to be taken when you can no longer make health care choices for yourself. It tells what health care you want or do not want. You should talk about your wishes with your doctor, family and friends. These steps will not change your health care benefits.

What are advance health care directives?

By State of New Mexico and federal law, you have the right to make an advance directive. It is a document that lets you say exactly how you wish to be treated if you are too sick to make health care decisions. An advance directive will help your doctor and family make choices about your health care. You can also name someone to make your health care decisions. That person is called a surrogate or an agent. He or she has the right to refuse or stop treatment for you in some cases.

The document could be called an advance health directive, mental health advance directive, psychiatric advance directive or PAD, living will, durable health care power of attorney and/or durable mental health care power of attorney.

It is UnitedHealthcare Community Plan policy to let all adult Turquoise Care members know they can do this. State and federal law says hospitals, nursing homes, and other providers have to tell you about advance directives. They need to explain your legal choices about medical decisions. The law was made to give you more control during times when you may not be able to make health care decisions.

UnitedHealthcare Community Plan follows the regulations in the Mental Health Care Treatment Decisions Act [24-7B-1 NMSA 1978] and the federal regulation 42 CFR 489 subpart I and 42 CFR 422.128.

How do I get an advance directive?

Contact Member Services or your Care Coordinator at **1-877-236-0826**. If you are speech or hearing impaired, call TTY **711**.

You can also call the State of New Mexico Aging and Disability Resource Center: **1-800-432-2080**.

Who has the right to make care decisions?

You do, if you are an adult and able to let providers know your wishes. You say what health care you do not want. This means you give consent before you have treatment or services. You can refuse to give consent if there is health care you do not want.

What if I am unable to let providers know what I want?

You still have some control if you signed an advance directive. You may name someone to make decisions for you. Your doctor must put in your record whether you have an advance directive. If you have not named anyone, your doctor must find a person allowed by law to make decisions.

Who can make health decisions for me if I can't and I have no advance directive?

A court may appoint a guardian for you. Otherwise, your doctor must find a person to make care decisions for you. Your doctor would pick from this list:

1. Your spouse, unless you are legally separated.
2. Another adult in a long-term relationship with you who has shown the care of a spouse (a domestic partner).
3. Your adult child or the majority of your adult children.
4. Your mother or father.
5. Your adult brother or sister.
6. Another adult who has shown special concern for you and knows your values.

If these persons cannot agree, they must go to court to get a guardian. Your doctors can ask the person to swear in writing that he or she has authority.

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

You can keep anyone from making decisions for you by saying so in writing or by telling your provider. If you are able to make your own decisions again (even if someone else did so for a while), your decisions will be followed.

What are my options for making an advance directive?

In New Mexico, you can make these directives:

- **A Durable Power of Attorney for Health Care** — This lets a person act in your place and make decisions about your care. Unless you say otherwise, this person can give consent or refuse to give consent for your treatment and services. This directive may tell what care you want or do not want. This could include not giving or stopping care if you are in a "terminal condition." A "terminal condition" is when a patient cannot be cured and will die without treatment. (Two doctors must state this in writing.) A patient is also in a "terminal condition" if in a permanent vegetative state or an irreversible coma.
- Please send to:
  UnitedHealthcare Community Plan Turquoise Care
  Attn: Compliance
  609 Broadway Boulevard NE, Suite 125
  Albuquerque, NM 87102
  Fax: 1-855-294-0661
- **Individual Instructions for Health Care** — A written statement about health care you want or do not want if you cannot make these decisions. For example, your Instructions can say if you would want to be fed through a tube if you were not conscious and not likely to recover. You may tell doctors to stop or not give treatment to sustain life if you are in a "terminal condition." You can tell doctors if you want other care to sustain life.

Must my advance directive be followed?

Yes. Your doctor, other providers, and your surrogate must follow your advance directive if they know about it. You should tell them.

Must a lawyer do my advance directive?

No. There are local and national groups that may help you, including your Care Coordinator. Be sure any form you use is valid under New Mexico law. You may also tell your doctor in words so he or she can write it down.

Who should have a copy of my advance directive?

Give a copy to your doctor and any health center you enter. If you have a Durable Power of Attorney for Health Care, give a copy to the person you name. You may give a copy to your doctor. You should keep a copy for yourself.

Do I have to make an advance directive?

No. It is up to you. A provider cannot refuse care based on whether you have one. You have the right to receive medical and behavioral health care even if you do not have an Advance Directive.

Can I change or cancel my advance directive?

Yes. If you do, let anyone who has a copy know.

What if I already have an advance directive?

You may want to review it. If it was done in another state, be sure it is valid in New Mexico. A new advance directive replaces any old ones.

Updating your information

To ensure that the personal information we have for you is correct, please tell us if and when any of the following changes:

- Marital status
- Address
- Member name
- Phone number
- You become pregnant
- Family size (new baby, death, etc.)
- Other health insurance

Please call Member Services at **1-877-236-0826**, TTY **711**, if any of this information changes. UnitedHealthcare Community Plan needs up-to-date records to tell you about new programs, to send you reminders about healthy checkups, and to mail you member newsletters, ID cards and other important information.

Are you interested in receiving digital documents, emails and texts? Update your preferences here: **www.myuhc.com/communityplan/preference**. Register online to view benefits, find a PCP and update your communication preferences to receive emails and text notifications.

Indian Health Service (IHS) and Tribal facilities

IHS provides medical and public health services to American Indians and Alaskan Natives. Members of Turquoise Care who are American Indian or Alaskan Native may get care at any of these locations:

Albuquerque area Indian health service facilities		
Acoma Canoncito Laguna Indian Hospital	80 B Veterans Boulevard Acoma Pueblo, NM 87034	505-552-5300
Alamo Navajo Health Center	Highway 169 North, P.O. Box 907 Magdalena, NM 87825	505-854-2626
Albuquerque Area IHS Dental Clinic	9169 Coors Road, NW, P.O. Box 67830 Albuquerque, NM 87193 (On SIPI campus)	505-346-2306
Albuquerque Area Indian Health Board	7001 Prospect Pl NE Albuquerque, NM 87110	505-764-0036
Albuquerque Indian Hospital	801 Vassar Drive, NE Albuquerque, NM 87106	505-248-4000
Canoncito Health Center	129 Medicine Horse Drive Tohajiilee, NM 87026	505-908-2307
Cochiti Health Clinic	255 Cochiti Street, P.O. Box 105 Cochiti Pueblo, NM 87072	505-465-2587
Eight Northern Indian Pueblos	325 Eagle Drive Ohkay Owingeh, NM 87566	505-747-1593
Five Sandoval Indian Pueblos, Inc. Behavioral Health Services	4321 Fulcrum Way NE B Rio Rancho, NM 87144	505-867-3351
Isleta Health Center	1 Sagebrush Street, P.O. Box 580 Isleta Pueblo, NM 87022	505-869-3200
Isleta Pueblo Behavioral Health	1 Sagebrush Street, P.O. Box 580 Isleta Pueblo, NM 87022	505-869-3200
Jemez Health Clinic	110 Sheep Spring Way, P.O. Box 279 Jemez Pueblo, NM 87024	575-834-7413

Albuquerque area Indian health service facilities (continued)		
Jicarilla Service Unit	500 Mundo Road Dulce, NM 87528	575-759-3291
Kewa Health Center (formerly Santo Domingo)	85 NM-22 Kewa Pueblo, NM 87052	505-465-2996
Laguna Community Health Center	6 Basswood Road Paraje, NM 87007	505-431-0703
Mescalero Community Services	107 Sunset Loop, P.O. Box 228 Mescalero, NM 88340	575-464-4432
Mescalero Indian Health Center	318 Abalone Loop Mescalero, NM 88340	575-464-4441
New Sunrise Regional Treatment Center	20 Mockingbird Drive San Fidel, NM 87049	505-552-5500
Pine Hill Health Center – Ramah Navajo	BIA Route 125, P.O. Box 310 Pine Hill, NM 87357	505-775-3271
Pueblo of Laguna Behavioral Health	7 Rio San Jose Road (Across the Post Office) Old Laguna, NM 87026	505-552-6513
Sandia Health Clinic	203 Sandia Day School, P.O. Box 6008 Bernalillo, NM 87004	505-867-4487
San Felipe Health Clinic	Cedar Street #4, P.O. Box 4344 San Felipe, NM 87001	505-867-2739
Santa Ana Health Clinic	2 Dove Road, Box 02C Dove Road Bernalillo, NM	505-867-2497
Santa Clara Health Center	Route 5, Box 446 Espanola, NM 87532	505-753-9421
Santa Fe Indian Center	1700 Cerrillos Road Santa Fe, NM 87501	
Santo Domingo Behavioral Health	10 Tesuque Street Santo Domingo Pueblo, NM 81052	505-465-2733

Albuquerque area Indian health service facilities (continued)		
Southern Ute Tribal Clinic	69 Capote Dr Ignacio, CO 81137	970-563-4581
Taos/Picuris Service Unit	1090 Goat Springs Road Taos, NM 87571	575-758-6977
Taos Pueblo Health and Community Services Division	Day School Road 716 Taos, NM 87571	575-758-7824
To'hajiilee Behavioral Health	I-40, Exit 131, North 3 miles To'hajiilee, NM 87026	505-833-1571
Ute Mountain Ute Health Center	Rousting Willow Complex D Towaoc, CO 81334	970-565-4441
Ysleta Del Sur Pueblo Community Health Center	9314 Juanchido Lane El Paso, TX 79907	915-858-1076
Zia Health Clinic	155 B Capital Square Drive Zia Pueblo, NM 87053	505-867-5258
Zuni Indian Hospital	Route 301 North, B Street, P.O. Box 467 Zuni, NM 87327	505-782-7405
Zuni Pueblo Division of Health Services	1203 B State Highway 53 Zuni, NM 87327	505-782-7233
Navajo area Indian health service facilities		
Chinle Comprehensive Health	P.O. Drawer PH Chinle, AZ 86503	928-674-7001
Crownpoint PHS Indian Hospital	Highway Junction 587, Navajo Route 9 P.O. Box 358, Crownpoint, NM 87313	505-786-5291
Crownpoint-Thoreau Health Clinic	03 Navarre Street Thoreau, NM 87323	505-862-8250
DBS Shiprock Treatment Center Outpatient	Highway 491, P.O. Box 160 Shiprock, NM 87420	505-368-1438

Navajo area Indian health service facilities (continued)		
Dzilth-NA-O-Dith-Hle Health Center	6 Road 7586 Bloomfield, NM 87413	505-960-7801
Fort Defiance Indian Hospital	Highway 12, Navajo Route 110, P.O. Box 649, Fort Defiance, AZ 86504	928-729-8000
Fort Wingate Clinic	520 B Shush Drive Fort Wingate, NM 87316	505-722-1770
Four Corners Regional Health Center	US Hwy. 160 and Navajo Route 35 HC 61 Box 30, Teec Nos Pos, Arizona 86514	928-656-5000
Gallup Indian Medical Center	516 Nizhoni Boulevard Gallup, NM 87305	505-722-1000
Kayenta Health Center	394.3 US-160, Kayenta, AZ 86033	928-697-4000
Nahata'Dziil Health Station	Chih Toh Boulevard, Sanders, AZ 86512	928-688-5600
Northern Navajo Medical Center	Highway 491, P.O. Box 160 Shiprock, NM 87420	505-368-6260
Pueblo Pintado Health Station	E. Route 9, Crownpoint, NM 87313	505-655-3301
Sanostee Health Station	Off Highway 491 North, Navajo Route 34, P.O. Box 160, Shiprock, NM 87420	505-368-6001
Thoreau Health Station	Highway 371, P.O. Box 368 Thoreau, NM 87313	505-862-8250
Toadlena Health Station	Navajo Route 19 Toadlena, NM 87324	505-368-6001
Tohatchi Indian Health Center	07 Ch'ooshgai, P.O. Box 142 Tohatchi, NM 87325	505-733-8100
Tsaile Health Center	Highway 64, P.O. Box 467 Tsaile, AZ 86556	928-724-3600

Navajo area Indian health service facilities (continued)		
Tuba City Regional Health Care	167 N Main Street, P.O. Box 600 Tuba City, AZ 86045	866-976-5491
Utah Navajo Health Systems, Inc.	East Highway. 262, P.O. Box 130 Montezuma Creek, UT 84534	435-651-3291

Fraud and abuse

Health care fraud and abuse

UnitedHealthcare Community Plan of New Mexico Anti-Fraud and Abuse Program mission is to identify, investigate, prevent paying and recover fraudulent and abusive Medicaid health care claims. Health care fraud and abuse is against the law. State and federal laws require us to report fraud and abuse.

Who commits fraud and abuse?

Anyone can commit fraud and abuse. Some examples include doctors, nurses, employees of medical offices, dentist, medical equipment suppliers, caregivers, members, or pharmacies.

What is fraud?

When a person is dishonest on purpose. This means they know or should know that what they are doing could result in some benefit to them or another person that they are not supposed to get.

What is abuse?

Abuse happens when providers or members do things that do not follow good financial, business or medical standards. This can result in unnecessary costs and can result in payment for services or treatment that are not medically necessary. It can result in services that do not meet professionally recognized standards for health care. Costs that are not necessary because of bad management or practices.

Some examples of provider health care fraud and abuse include:

- Billing for services/goods that were not provided
- Billing a procedure that does not match the diagnosis or problem
- Billing for services/goods not covered (e.g., experimental services) and/or for services to ineligible members

- Billing for services using a provider's name that did not provide care
- Asking for, offering, or getting a kickback, bribe or rebate
- Having members come in for office visits more often than needed
- Questionable prescription practices
- Billings by fictitious, sanctioned, and/or unqualified providers
- Excessive fees charged for services/goods

Some examples of member health care fraud and abuse include:

- Allowing a caregiver to claim hours they did not work
- Abusing the Self-Directed Community Benefit
- Selling/loaning member identification information
- Using someone else's medical card
- Selling prescriptions and/or prescription medications
- Not letting UnitedHealthcare know about other health insurance you have
- Abusing transportation services
- Drug seeking behavior
- Doctor shopping in order to get services that are not needed

Explanation of benefit letters:

You may receive letters in the mail asking if you have received the services listed. It will provide the date, a description of the service and possibly the amount charged. Review these letters carefully and report anything that does not look right by calling the number on the letter.

How do I report fraud or abuse?

If you suspect fraud or abuse by a caregiver, medical provider, behavioral health provider, another member or anyone else, you can report it safely without providing your name or identity to the State or to UnitedHealthcare. There are email addresses and websites provided below that you can use to report suspected fraud or abuse 24 hours a day 7 days a week.

You can report to UnitedHealthcare Community Plan. You can do this by calling your Care Coordinator, by telephone or through our website at:

UnitedHealthcare Fraud Hotline: **1-844-359-7736**

Website: **myuhc.com/communityplan/nm** or **uhc.com/fraud**

When reporting a provider, please let us know as much information as possible. It can include:

- Name, address, and phone
- Name and address of facility
- Medicaid number of provider and facility is helpful
- Type of provider
- Names and numbers of witnesses
- Dates and summary of events

When reporting a member, please let us know as much information as possible. It can include:

- The person's name
- The person's date of birth, Social Security, or case number, if available
- The city where the person lives
- Specific details about the abuse or fraud

What happens after I report?

- An investigation will start looking at your concerns. If fraud, waste, or abuse found, UHC will address it with the responsible party.
- In some cases, your concern may be referred to the Medicaid Fraud & Elder Abuse Division (MFEAD) if fraud is found. MFEAD can investigate and determine if a civil or criminal case is needed to address the allegation.

Member Advisory Board meetings

UnitedHealthcare Community Plan wants to hear from our members. We have a Member Advisory Board. The board is made up of people like you. The board suggests ways we can better serve UnitedHealthcare Community Plan Turquoise Care members. Speak with your Care Coordinator if you want to learn more or if you would like to be a part of these meetings.

Safety and protection from discrimination

Patient safety is very important to us. Although we do not direct care, we want to make sure that our members get safe care. We track quality-of-care issues, develop guidelines to promote safe care, provide information to members about patient safety, and work with hospitals, doctors and others to improve continuity and coordination between sites of care. If you would like more information on patient safety or places to get information, call Member Services at **1-877-236-0826**, TTY **711**.

UnitedHealthcare Community Plan and its providers are prohibited from discriminating against anyone because of age, race, ethnicity, sex or religion. UnitedHealthcare Community Plan providers must follow the Americans with Disabilities Act and cannot discriminate on the basis of health or mental health, need for health care or pre-existing conditions. If you think you have been subject to any form of discrimination, please call Member Services at **1-877-236-0826**, TTY **711**, immediately.

Clinical practice guidelines and new technology

UnitedHealthcare Community Plan gives our providers clinical guidelines that have information about the best way to provide care for some conditions. Each clinical guideline is an accepted standard of care in the medical profession, which means other doctors agree with that approach. We want to improve your health by giving our providers information that supports their clinical practices, consistent with nationally recognized standards of care.

If you have any questions about UnitedHealthcare Community Plan's clinical guidelines or would like a paper copy of a clinical practice guideline, please call Member Services at **1-877-236-0826**, TTY **711**. You can also find the clinical practice guidelines on our website at **myuhc.com/communityplan/nm**.

New technology assessment

Some medical practices and treatments are not yet proven to be effective. New practices, treatments, tests and technologies are reviewed nationally by UnitedHealthcare Community Plan to make decisions about new medical practices and treatments and what conditions they can be used for. This information is reviewed by a committee of UnitedHealthcare Community Plan doctors, nurses, pharmacists and guest experts who make the final decision about coverage. If you would like more information about how we make decisions about new medical practices and treatments, call us at **1-877-236-0826**, TTY **711**.

Member rights and responsibilities

UnitedHealthcare Community Plan Turquoise Care Member Bill of Rights and Responsibilities agrees with federal and state regulations and the National Committee for Quality Assurance Accreditation standards. UnitedHealthcare Community Plan Turquoise Care does not have policies limiting conversations between you and your provider and we do not tell providers to limit information about treatment options.

Member rights

All members of UnitedHealthcare Community Plan's Turquoise Care health plan and/or their legal guardians have **rights**. These include the right to:

- Get a written Member Bill of Rights
- Be treated fairly and with respect and with recognition to your dignity and your right to privacy
- Have health information kept private
- Refuse care
- Receive health care services without discrimination
- Get information in another format that complies with the Americans with Disabilities Act
- Take part in all your health care decisions with your providers
- Be informed about treatment options in a way you can understand
- Have discussions of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage
- Informed consent, which is the right to have a clear understanding of the facts, risks and any possible outcome of a treatment
- Participate in understanding physical and behavioral health problems and develop mutually agreed-upon treatment goals
- Pick a surrogate to help with care decisions
- Seek a second opinion in the UnitedHealthcare Community Plan Turquoise Care network. Or UnitedHealthcare Community Plan will arrange for a second opinion outside the network at no cost. This may be asked for when the member or guardian needs to know more about treatment or thinks the provider is not giving requested care.
- Voice a grievance or an appeal about UnitedHealthcare Community Plan or the care received and get a timely answer
- Use the UnitedHealthcare Community Plan Grievance process and the State of NM HSD Fair Hearings process without fear of retaliation

Other plan details

- Choose from the UnitedHealthcare Community Plan Turquoise Care network of available service providers and follow the referral and prior authorization requirements
- Use any hospital or other setting for emergency care
- State wishes in advance directives on health care
- Ask for and get a copy of your medical records in a timely manner
- Get information on UnitedHealthcare Community Plan Turquoise Care, its services, practitioners and providers and member rights and responsibilities
- Be free from harassment by UnitedHealthcare Community Plan Turquoise Care or its providers in contract disputes
- Be free from restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- Pick an MCO and use switch enrollment rights without harassment
- Use rights without any effect on the way UnitedHealthcare Community Plan, providers, or the State treat you
- Expect that UnitedHealthcare Community Plan complies with federal and state laws
- Get information about coverage and limits
- Be told what will happen if you do not get care
- Have your doctor ask if you want care. In an emergency, if you can't sign a form, and your health is in danger, the doctor can give care without asking.
- Expect that UnitedHealthcare Community Plan will not interfere with you or the doctor or when talking about care
- Have UnitedHealthcare Community Plan help you find another doctor if the doctor won't give care due to moral or religious beliefs
- Not have any doctor act against you or try to influence you
- Tell UnitedHealthcare Community Plan if someone else should get information or help make decisions about your care
- Use these rights when you want to
- Make recommendations regarding these rights
- Get the services you need as determined by your doctor and UnitedHealthcare Community Plan as required by the State of New Mexico
- Get information on how UnitedHealthcare Community Plan does business and how to make an appeal
- Get all rights under law or rule as a patient in a licensed care facility
- Know if benefits, services, or provider networks change

- Get information on agreements between UnitedHealthcare Community Plan Turquoise Care and its providers that may limit services
- Have access to providers near where you live or work
- Get affordable health care with limits on your cost. This includes the right to seek care from a non-network provider. It means you should be told your costs when care is from a non-network provider, or given without required prior authorization.
- Be told why care is denied and be allowed to appeal and to get help from the State
- If a member has been incorrectly overcharged copayments, the member has a right to be repaid by the provider
- The HSD Income Support Division (ISD) determines eligibility for most categories of Medicaid. If the member household disagrees with the household income calculation, then the household may request a HSD fair hearing.
- Members have a right to request from UnitedHealthcare Community Plan at any time, an accounting of his or her household's accrued copayment total(s). If the member disagrees with the MCO's accounting of accrued copayments, the member may file an appeal directly with UnitedHealthcare Community Plan Member Services.

Member responsibilities

Members of UnitedHealthcare Community Plan Turquoise Care have **responsibilities**.
These include to:

- Understand your Member Rights under Turquoise Care
- Ask questions
- Ask UnitedHealthcare Community Plan about your benefits before getting care
- Pick a primary care provider. Contact the primary care provider first for non-emergency cases.
- Speak with your primary care provider before going to a specialist. Make changes in a primary care provider in the ways specified by UnitedHealthcare Community Plan.
- Show the member ID card before getting care and keep the ID card safe from another person using it
- Keep, reschedule, or cancel an appointment in advance rather than to simply not show up
- Use emergency care only for an injury or illness that would threaten life or damage health if not cared for right away
- You do not need to contact your primary care provider for an emergency, family planning, or services from the Indian Health Service
- Share health information that UnitedHealthcare Community Plan, your doctor or other health provider need to provide care

- Understand your health condition, take part in your treatment, and work with your provider to make choices, and do the best you can to stay healthy
- Follow the advice, plans, and instructions that you have agreed to with your doctor and let your doctor know if you need to make a change
- Treat all staff with respect and courtesy
- Tell UnitedHealthcare Community Plan of any change in address or phone number
- Members or their legal guardians have a responsibility to pay for all required copayments and/or Cost Share at the time services are rendered. This includes the Medical Care Credit that the Nursing Facility may collect when applicable.
- In the event of non-payment of the applicable copay or cost share, the provider of care or UnitedHealthcare may exercise all appropriate and legal action needed to recoup the copay or cost share amount owed

UnitedHealthcare guarantees equal access to our services and proudly complies with state and federal laws designed to ensure all members receive the highest quality of service possible. UnitedHealthcare will not discriminate against any member based on age, race, gender, color, religion, national origin, ancestry, disability, marital status, covered veteran status, sexual orientation, gender identity and/or expression, status with respect to public assistance or any other characteristic protected by state, federal or local law.

Any person, any employee of UnitedHealthcare Community Plan or any provider contracted with UnitedHealthcare Community Plan that has a reasonable cause to believe that a member is being abused, neglected or exploited must report that information to Adult Protective Services. In New Mexico, the toll-free number is 1-866-654-3219. It is against the law to retaliate against anyone making an abuse report in good faith.

Some members may receive services under certain waiver programs. If an incident happens to a member receiving care from an agency under a waiver program, UnitedHealthcare Community Plan is required to follow up on the incident. Part of this requirement includes recording the incident in a state database and UnitedHealthcare Community Plan nurses and care coordinators following up with agencies, members, and caregivers to make sure a member is safe. UnitedHealthcare Community Plan has to provide reports every month to the state about members who have critical incidents. Critical incidents are events such as death, use by a member of emergency services, a hospital stay that isn't planned in advance, abuse, neglect or exploitation of a member or by a member. Critical incidents can also include home safety issues or involvement with law enforcement.

Grievances and appeals

What is a grievance?

A grievance is an issue or problem you have with your health plan, provider or health services. If you are unhappy with the care you are getting, you or someone acting for you can file a grievance with UnitedHealthcare. You can also file a grievance if you are not happy with UnitedHealthcare.

What should I do if I have a grievance?

You can first talk to your doctor or provider if you have questions or concerns about your care. They can work with you on fixing the problem. If the problem isn't fixed, you can call us.

You may file a grievance over the phone with Member Services at **1-877-236-0826**, TTY **711**.

You may file grievances online at **member.uhc.com/CommunityPlan**.

You can send your written grievance to:

UnitedHealthcare Community Plan Turquoise Care
Appeals and Grievances
P.O. Box 31364
Salt Lake City, UT 84131-0364

Fax: 1-801-994-1082

Email: **UHCCP_NM_AG@uhc.com**

What are the time limits for filing a grievance?

You may file a verbal or written grievance at any time from the date of the event you want to complain about.

How long will it take to process my grievance?

We will send you a letter within 5 business days after we receive your grievance telling you that we received it. UnitedHealthcare Community Plan has 30 days to review your concerns. Once we have an answer, we will send another letter telling you what our grievance decision is. This is called a standard grievance.

Who can file a grievance?

A member may file a grievance orally, online or in writing. The legal guardian for children or incapacitated adults, a representative as stated in writing, or a provider acting with the member's written consent can file a grievance on a behalf of a member.

If you have questions

You can call Member Services at **1-877-236-0826**, TTY **711**, or go to **myuhc.com/communityplan/nm** and submit a question via secure messaging. We will respond to you within 1 business day.

What is an appeal?

An appeal is a request for review of a UnitedHealthcare Community Plan decision or adverse action. You or someone acting for you can file an appeal if you disagree with the decision. An adverse action is when UnitedHealthcare Community Plan denies, delays, limits or stops a service. We will tell you when we make a decision or action in writing, called a Notice of Adverse Action letter.

You must exhaust the UnitedHealthcare Community Plan appeal process prior to requesting a State Fair Hearing.

All members can file an appeal through these processes. You may file an appeal over the phone with Member Services at **1-877-236-0826**, TTY **711**.

You may file appeals online at **member.uhc.com/CommunityPlan**.

You may also file a written appeal by sending it to:

UnitedHealthcare Community Plan
Turquoise Care Appeals and Grievances
P.O. Box 31364
Salt Lake City, UT 84131-0364

Fax: 1-801-994-1082

Email: **UHCCP_NM_AG@uhc.com**

Do I need a Notice of Adverse Action letter to appeal?

Yes, this letter will let you know when a service is denied, delayed, limited, or stopped. It will also give you the instructions on how to file an appeal.

How long do I have to appeal?

You have to appeal within 60 days from the date on the Notice of Action letter. You can start an appeal over the phone, online or in writing.

How long will it take to process my appeal?

We will send you a letter within 5 business days after we receive your appeal telling you that we received it. UnitedHealthcare Community Plan has 30 days to review your concerns. Once we have an answer, we will send another letter telling you what our appeal decision is. This is called a standard appeal.

If you or UnitedHealthcare need more time to get or submit information from other places, the appeal process may take up to 14 calendar days longer. If UnitedHealthcare is requesting an extension, we must first get an approval from the State of New Mexico. If we need more information, we will give you written notice of the reason for the delay.

What if I want to keep my services?

You may have the right to request that you continue getting the services in question while your appeal with UnitedHealthcare Community Plan or your Fair Hearing with the State of NM HSD is in process. You have the right to receive continued benefits only if these conditions are met:

- You must request an appeal and ask for your benefits to continue within 10 calendar days from the date the Notice of Action letter was mailed. If you asked for your benefits to continue during the appeal process, and received approval, your benefits will automatically continue through the Fair Hearing process. Should you choose to discontinue your benefit during the Fair Hearing process, you must contact UnitedHealthcare to end services.

Please be aware, if the result of the appeal or Fair Hearing is not in your favor you may have to pay for the services received.

What is an expedited appeal?

An expedited appeal is when UnitedHealthcare Community Plan or your provider thinks a fast decision is needed due to your health. It is when the time for a regular appeal could risk your health. You or someone acting for you can file an expedited appeal. The request may be made in writing, online or by phone. The request must explain in detail why an expedited appeal is needed. We will tell you or your doctor the outcome within 72 hours. We will send a letter telling you and your doctor the outcome. Your written consent is not required if your provider requests an expedited appeal.

What happens if UnitedHealthcare Community Plan denies the request for an expedited appeal?

If an expedited appeal request is denied, it goes through the normal appeal process. It will be resolved within 30 days. UnitedHealthcare Community Plan will try to call you to tell you that the appeal is not going to be expedited. We will follow up in writing within 2 calendar days. You may file a grievance if UnitedHealthcare denies your request for an expedited appeal.

If you have questions

You can call Member Services at **1-877-236-0826**, TTY **711**, or go to **myuhc.com/communityplan/nm** and submit a question via secure messaging. We will respond to you within 1 business day.

Can I ask for a Fair Hearing?

If you don't agree with our appeal decision, you or someone acting for you has the right to request a Fair Hearing with the State of NM HSD. **You can only ask for a Fair Hearing after you have exhausted the UnitedHealthcare appeal process.** You must request a Fair Hearing within 90 calendar days for standard appeals or 30 calendar days for quick appeals of the final appeal decision.

You can ask for a Fair Hearing if you disagree with UnitedHealthcare's decision to terminate, modify, suspend, reduce, delay or deny a service. You can also ask for a Fair Hearing if you think UnitedHealthcare did not act promptly.

You have the right to have someone represent you at the hearing. The parties to the Fair Hearing include representatives from UnitedHealthcare Community Plan, as well as the member and his or her representative or the representative of a deceased member's estate. The State has up to 60 days to process your Fair Hearing request. If you want your services to continue during a Fair Hearing, you make this request within 10 days from the date of the Notice of Appeal Resolution letter. If you requested continuation of benefits and the result of the Fair Hearing is not in your favor, you may have to pay for the services received.

You can request a Fair Hearing by calling or writing to:

State of NM HSD
Office of Fair Hearings
37 Plaza La Prensa
P.O. Box 2348
Santa Fe, NM 87504-2348

Telephone: 1-800-432-6217, then press option 6 or 1-505-476-6213

Fax: 1-505-476-6215

Email: **HSD-FairHearings@state.nm.us**

Health Plan Notices of Privacy Practices

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

Effective January 1, 2024

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

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

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

HI is information about your health or medical services. We have the right to make changes to this notice of privacy practices. If we make important changes, we will notify you by mail or e-mail. We will also post the new notice on our website. We will notify you of a breach of your HI.

How we collect, use, and share your information

We collect, use, and share your HI with:

- You or your legal representative.
- Certain government agencies. To check to make sure we are following privacy laws.

We have the right to collect, use and share your HI for certain purposes. This may 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.** To process payments and pay claims. This may include coordinating benefits.
- **For Treatment or Managing Care.** To help with your care. For example, we may share your HI with a hospital you are in, to help them provide medical care to you.
- **For Health Care Operations.** To run your business. For example, we may talk to your doctor to tell him or her about a special disease management or wellness program available to you. 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.** If you receive health insurance through your employer, we may give enrollment, disenrollment, and summary HI to your employer. We may give them other HI if they properly limit its use.
- **For Underwriting Purposes.** To make underwriting decisions. We will not use your genetic HI for underwriting purposes.
- **For Reminders on Benefits or Care.** We may send reminders about appointments you have and information about your health benefits.
- **For Communications to You.** We may contact you about your health insurance benefits, healthcare or payments.

We may collect, use, and share your HI as follows:

- **As Required by Law.** To follow the laws that apply to us.
- **To Persons Involved with Your Care.** A family member or other person that helps with your medical care or pays for your care. This also may be to a family member in an emergency. This may happen if you are unable to tell us if we can share your HI or not. If you are unable to tell us what you want, we will use our best judgment. If allowed, after you pass away, we may share HI with family members or friends who helped with your care or paid for your care.
- **For Public Health Activities.** For example, to prevent diseases from spreading or to report problems with products or medicines.
- **For Reporting Abuse, Neglect or Domestic Violence.** We may only share with certain 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.** For example, 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.** To public health agencies or law enforcement, for example, in an emergency or disaster.
- **For Government Functions.** For military and veteran use, national security, or certain protective services.
- **For Workers' Compensation.** If you were hurt at work or to comply with labor laws.
- **For Research.** For example, to study a disease or medical condition. We also may use HI to help prepare a research study.
- **To Give Information on Decedents.** For example, to a coroner or medical examiner who may help to identify the person who died, why they died, or to meet certain law. We also may give HI to funeral directors.
- **For Organ Transplant.** For example, to help get, store or transplant organs, eyes or tissue.

- **To Correctional Institutions or Law Enforcement.** For persons in custody, for example: (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.** To give you services, if needed. These are companies that provide services to us. They agree to protect your HI.
- **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 Use Disorder
  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 or share your HI as described in this notice or with your written consent. We will get your written consent to share psychotherapy notes about you, except in certain cases allowed by law. 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 marketing mailings. If you give us your consent, you may take it back. To find out how, call the phone number on your health insurance ID card.

Your rights

You have the following rights.

- **To ask us to limit** our use or sharing for treatment, payment, or health care operations. You can ask to limit sharing with family members or others that help with your care or pay for your care. We may allow your dependents to ask for limits. **We will try to honor your request, but we do not have to do so.** Your request to limit our use or sharing must be made in writing.
- **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 as allowed by state and federal law. We take verbal requests but may ask you to confirm your request in writing. 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. 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. We will respond to your request in the time we must do so under the law. Mail this to the address below. If we deny your request, you may add your disagreement to your HI.
- **To get an accounting** of when we shared your HI in the six years prior to your request. This will not include when we shared HI 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.
- **In certain states, you may have the right to ask that we delete** your HI. Depending on where you live, you may be able to ask us to delete your HI. We will respond to your request in the time we must do so under the law. 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.** If you have questions about this notice, or you want to use your rights, **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 Grievance.** If you think your privacy rights have been violated, you may send a grievance 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 grievance.

[1] This Medical Information Notice of Privacy Practices applies to health plans that are affiliated with UnitedHealth Group. For a current list of health plans subject to this notice go to **https://www.uhc.com/privacy/entities-fn-v2**.

Financial Information Privacy Notice

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

Effective January 1, 2024

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

Information we collect

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

Sharing of FI

We will only share FI as permitted by law.

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

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

Confidentiality and security

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

Questions about this notice

Please **call the toll-free member phone number on 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 health plans affiliated with UnitedHealth Group, and the following UnitedHealthcare affiliates: ACN Group of California, Inc.; AmeriChoice Corporation.; Benefitter Insurance Solutions, Inc.; Claims Management Systems, Inc.; Dental Benefit Providers, Inc.; Ear Professional International Corporation; Excelsior Insurance Brokerage, Inc.; gethealthinsurance.com Agency, Inc. Golden Outlook, Inc.; Golden Rule Insurance Company; HealthMarkets Insurance Agency; Healthplex of CT, Inc.; Healthplex of NJ, Inc.; Healthplex, Inc.; HealthSCOPE Benefits, Inc.; International Healthcare Services, Inc.; Level2 Health IPA, LLC; Level2 Health Holdings, Inc.; Level2 Health Management, LLC; Managed Physical Network, Inc.; Optum Care Networks, Inc.; Optum Health Care Solutions, Inc.; Optum Health Networks, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; Physician Alliance of the Rockies, LLC; POMCO Network, Inc.; POMCO, Inc.; Real Appeal, LLC; Solstice Administrators of Alabama, Inc.; Solstice Administrators of Missouri, Inc.; Solstice Administrators of North Carolina, Inc.; Solstice Administrators, Inc.; Solstice Benefit Services, Inc.; Solstice of Minnesota, Inc.; Solstice of New York, 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. For a current list of health plans subject to this notice go to **https://www.uhc.com/privacy/entities-fn-v2**.

Discrimination is against the law. The company complies with applicable federal civil rights laws and does not discriminate, exclude people, or treat them differently based on race, color, national origin, age, disability, religion, or sex (including gender identity and sexual orientation).

You have the right to file a discrimination grievance if you believe you were treated in a discriminatory way by us. You can file a grievance and ask for help filing a grievance in person or by mail, phone, fax, or email at:

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

Email: **UHC_Civil_Rights@uhc.com**

You can also file a civil rights grievance with the U.S. Department of Health and Human Services, Office for Civil Rights:

Online: **hhs.gov/civil-rights/filing-a-complaint/index.html**

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

By phone: **1-800-368-1019** (TDD **1-800-537-7697**)

We provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified American Sign Language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

We also provide free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, please call Member Services at **1-877-236-0826**, TTY **711**, 8 a.m.–5 p.m. MT, Monday–Friday.

This notice is available at
https://www.uhc.com/legal/nondiscrimination-and-language-assistance-notices.

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1-877-236-0826, TTY 711

English: ATTENTION: Translation and other language assistance services are available at no cost to you. If you need help, please call the number above.

Spanish: ATENCIÓN: La traducción y los servicios de asistencia de otros idiomas se encuentran disponibles sin costo alguno para usted. Si necesita ayuda, llame al número que se indica arriba.

Navajo: BAA'ÁKOHWIINIDZIN: Hazaad bee naaltsoos ha'dil'įh dóó nááná ła' saad bee áka'e'eyeed doo bą́ą́h il'íníǵóó ná hóló̧go át'é. Shíka'a'doowoł nínízingo, t'áá sho̧go̧dí hódahgo béésh bee hane'í biká'ígíí bee hodíilnih.

Vietnamese: CHÚ Ý: Dịch vụ dịch thuật và hỗ trợ ngôn ngữ khác được cung cấp cho quý vị miễn phí. Nếu quý vị cần trợ giúp, vui lòng gọi số ở trên.

German: HINWEIS: Übersetzungs- und andere Sprachdienste stehen Ihnen kostenlos zur Verfügung. Wenn Sie Hilfe benötigen, rufen Sie bitte die obige Nummer an.

Chinese: 注意：您可以免費獲得翻譯及其他語言協助服務。如果您需要協助，請致電上列電話號碼。

Arabic : تنبيه: تتوفر خدمات الترجمة وخدمات المساعدة اللغوية الأخرى لك مجانًا. إذا كنت بحاجة إلى المساعدة، يُرجى الاتصال بالرقم أعلاه.

Korean: 참고: 번역 및 기타 언어 지원 서비스를 무료로 제공해 드립니다. 도움이 필요하시면 위에 명시된 번호로 전화해 주십시오.

Tagalog: ATENSYON: Ang pagsasalin at iba pang mga serbisyong tulong sa wika ay magagamit mo nang walang bayad. Kung kailangan mo ng tulong, mangyaring tawagan ang numero sa itaas.

Japanese: 注意：ほん訳やその他の言語サポートサービスを無料でご利用いただけます。サポートが必要な場合は、上記の番号までお電話ください。

French: ATTENTION : la traduction et d'autres services d'assistance linguistique sont disponibles sans frais pour vous. Si vous avez besoin d'aide, veuillez appeler le numéro ci-dessus.

Russian: ВНИМАНИЕ! Услуги перевода, а также другие услуги языковой поддержки предоставляются бесплатно. Если вам требуется помощь, пожалуйста, позвоните по указанному выше номеру.

Hindi: ध्यान दें: अनुवाद और अन्य भाषा सहायता सेवाएं आपके लिए निःशुल्क उपलब्ध हैं। अगर आपको मदद चाहिए तो कृपया ऊपर दिए गए नंबर पर कॉल करें।

Persian : توجه: خدمات ترجمه و سایر کمک‌های زبانی به صورت رایگان در اختیار شما قرار دارد. اگر به کمک نیاز دارید، با شماره بالا تماس بگیرید.

Thai: โปรดทราบ: มีบริการแปลและบริการช่วยเหลืออื่น ๆ ด้านภาษาให้สำหรับคุณโดยไม่มีค่าใช้จ่ายใด ๆ หากคุณต้องการความช่วยเหลือ โปรดโทรติดต่อหมายเลขด้านบนนี้

We're here for you

Remember, we're always ready to answer any questions you may have. Just call Member Services at **1-877-236-0826**, TTY **711**. You can also visit our website at **myuhc.com/communityplan/nm**.

UnitedHealthcare Community Plan
Turquoise Care
609 Broadway Boulevard NE, Suite 125
Albuquerque NM 87102

myuhc.com/communityplan/nm

1-877-236-0826, TTY **711**

United Healthcare®
Community Plan

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