FLORIDA COMMUNITY CARE'S
FLORIDA MEDICAID MEMBER HANDBOOK

FLORIDA®
COMMUNITY CARE

A LONG-TERM CARE PLUS PLAN

Thank you for choosing Florida Community Care!

Visit us at www.fcchealthplan.com

Questions? Call Member Services at 1-833-FCC-PLAN or TTY 711

FCC20191107EMSHBK001F

"**If you do not speak English**, call us at 1-833-FCC-PLAN. We have access to interpreter services and can help answer your questions in your language. We can also help you find a health care provider who can talk with you in your language."

Spanish: Si usted no habla inglés, llámenos al 1-833-FCC-PLAN. Ofrecemos servicios de interpretación y podemos ayudarle a responder preguntas en su idioma. También podemos ayudarle a encontrar un proveedor de salud que pueda comunicarse con usted en su idioma.

French: Si vous ne parlez pas anglais, appelez-nous au 1-833-FCC-PLAN. Nous avons accès à des services d'interprétariat pour vous aider à répondre aux questions dans votre langue. Nous pouvons également vous aider à trouver un prestataire de soins de santé qui peut communiquer avec vous dans votre langue.

Haitian Creole: Si ou pa pale lang Anglè, rele nou nan 1-833-FCC-PLAN. Nou ka jwenn sèvis entèprèt pou ou, epitou nou kapab ede reponn kesyon ou yo nan lang ou pale a. Nou kapab ede ou jwenn yon pwofesyonèl swen sante ki kapab kominike avèk ou nan lang ou pale a."

Italian: "Se non parli inglese chiamaci al 1-833-FCC-PLAN. Disponiamo di servizi di interpretariato e siamo in grado di rispondere alle tue domande nella tua lingua. Possiamo anche aiutarti a trovare un fornitore di servizi sanitari che parli la tua lingua."

Russian: «Если вы не разговариваете по-английски, позвоните нам по номеру 1-833-FCC-PLAN. У нас есть возможность воспользоваться услугами переводчика, и мы поможем вам получить ответы на вопросы на вашем родном языке. Кроме того, мы можем оказать вам помощь в поиске поставщика медицинских услуг, который может общаться с вами на вашем родном языке».

FLORIDA COMMUNITY CARE

Important Contact Information

Member Helpline	1-833-FCC-PLAN	Available 24 hours
Member Helpline TTY	711	Available 24 hours
Website	www.fcchealthplan.com	
Address	Florida Community Care 5200 Blue Lagoon Drive, Suite 500 Miami, FL 33316	

Non-emergency Transportation	Contact your case manager directly or at 1-833-FCC-PLAN for help with transportation to and from your medical appointments or LTC program services
Prescriptions/Pharmacy	CVS Contact your local CVS pharmacy or for questions about your pharmacy benefit call 1-877-888-8347
Vision	iCare 1-888-234-6408
Dental	Contact your case manager directly or at 1-833-FCC-PLAN for help with arranging these services
Hearing	Contact your case manager directly or at 1-833-FCC-PLAN for help with arranging these services
Case Manager	Contact your case manager directly or at 1-833-FCC-PLAN for help with coordinating all your medical care and LTC services
To report suspected cases of abuse, neglect, abandonment, or exploitation of children or vulnerable adults	1-800-96-ABUSE (1-800-962-2873) TTY: 711 or 1-800-955-8771 http://www.myflfamilies.com/service-programs/abuse-hotline
For Medicaid Eligibility	1-866-762-2237, TTY: 711 or 1-800-955-8771 http://www.myflfamilies.com/service-programs/access-florida-food-medical-assistance-cash/Medicaid
To report Medicaid Fraud and/ or Abuse or to file a complaint about a health care facility	1-888-419-3456 https://apps.ahca.myflorida.com/mpi-complaintform/
To request a Medicaid Fair Hearing	1-877-254-1055 1-239-338-2642 (fax) MedicaidHearingUnit@ahca.myflorida.com

To file a complaint about Medicaid services	1-877-254-1055 TDD: 1-866-467-4970 http://ahca.myflorida.com/Medicaid/complaints/
To find information for elders	1-800-96-ELDER (1-800-963-5337) http://elderaffairs.state.fl.us/doea/arc.php
To find out information about domestic violence	1-800-799-7233, TTY: 1-800-787-3224 http://www.thehotline.org/
To find information about health facilities in Florida	http://www.floridahealthfinder.gov/index.html

To find information about urgent care	First, contact your PCP.
	If you cannot reach your PCP, call your Case Manager at 1-833-FCC-PLAN.
	
	You may also check the Florida Community Care online directory. To find an urgent care, follow these instructions:
	• Select 'Urgent Care' from the Provider Type dropdown
	• Select one of the following:
	  ○ by zip code
	  ○ by distance from a zip code
	  ○ by city/county/state
	  ○ no preference
	• Enter your zip code, city, county, or state
	• Select any other options important to you (i.e.: languages spoken, etc.)
	• Select 'Search'

For an emergency	9-1-1 Or go to the nearest emergency room

FLORIDA COMMUNITY CARE

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Welcome to Florida Community Care's Statewide Medicaid Managed Care Plan

Florida Community Care (FCC) has a contract with the Florida Agency for Health Care Administration (Agency) to provide health care services to people with Medicaid. This is called the **Statewide Medicaid Managed Care (SMMC) Program**. You are enrolled in our SMMC plan. This means that we will offer you Medicaid services. We work with a group of health care providers to help meet your needs.

There are many types of Medicaid services that you can receive in the SMMC program. You can receive medical services, like doctor visits, labs, and emergency care, from a **Managed Medical Assistance (MMA)** plan. If you are an elder or adult with disabilities, you can receive nursing facility and home and community-based services in a **Long- term Care (LTC)** plan. If you have a certain health condition, like AIDS, you can receive care that is designed to meet your needs in a **Specialty** plan.

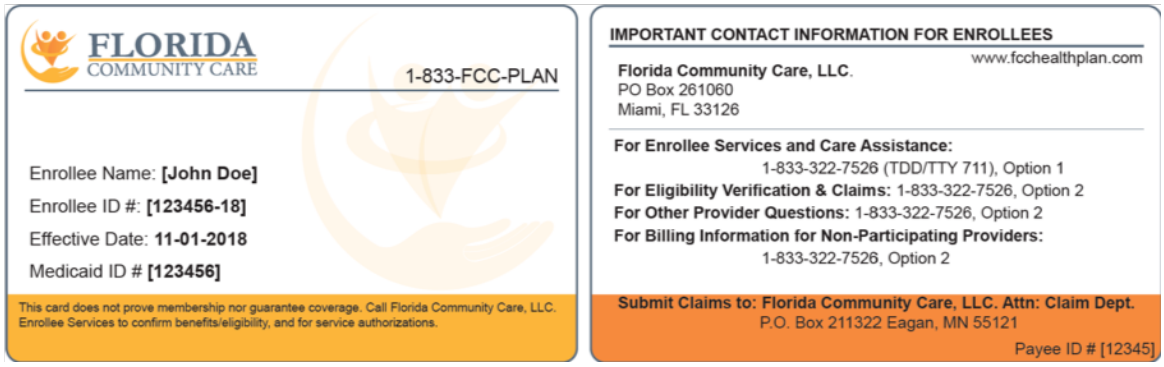
This handbook will be your guide for all health care services available to you. You can ask us any questions, or get help making appointments. If you need to speak with us, just call us at 1-833-FCC-PLAN.

Section 1: Your Plan Identification Card (ID card)

You should have received your ID card in the mail. Call us if you have not received your card or if the information on your card is wrong. Each member of your family in our plan should have their own ID card.

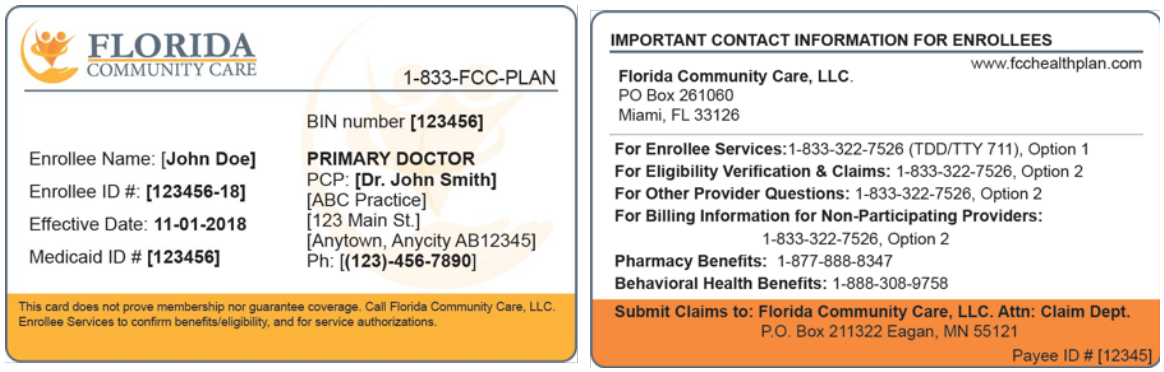
Carry your ID card at all times and show it each time you go to a health care appointment. Never give your ID card to anyone else to use. If your card is lost or stolen, call us so we can give you a new card.

For Members with Medicare coverage, your ID card will look like this:



NOTE: You will notice there is no PCP listed on your card. You will continue to see the PCP and any other doctors you are currently seeing under your Medicare benefits.

For Members without Medicare coverage, your ID card will look like this:



NOTE: A PCP will be assigned to you when you enroll in the Florida Community Care Plan. You may change to another PCP by calling Member Services at 1-833-FCC-PLAN.

Section 2: Your Privacy

Your privacy is important to us. You have rights when it comes to protecting your health information, such as your name, Plan identification number, race, ethnicity, and other things that identify you. We will not share any health information about you that is not allowed by law.

If you have any questions, call Member Services. Our privacy policies and protections are:

Our Responsibilities

Florida Community Care, LLC by law must keep your health information safe and private. We must tell you about our legal duties and privacy practices related to your health information. We must follow the terms of this notice.

Here are some examples of how we will use your information without your permission:

- For treatment *Example:* to arrange for referrals with a specialist
- To run our operations *Example:* to develop better services for you
- For payment *Example:* to pay your doctor
- If required or allowed by law for these reasons:
  - for help with public health and safety issues. *Example:* to report suspected abuse, neglect, or domestic violence
  - research purposes
  - to respond to an organ donation request
  - to work with a medical examiner or funeral director.
  - to address worker's compensation claims
  - law enforcement, and other government requests.
  - to respond to lawsuits, court orders and legal actions.
  - when a business associate performs certain functions on your behalf, such as payment.
  - to persons involved with your care. *Example:* a family member in an emergency. If you cannot object, we may decide if giving the information is in your best interests.

We may also use and share your health information with you or your authorized representative's written permission when:

- using or sharing psychotherapy notes as allowed by law, or
- in the release to third parties, or
- for certain marketing communications.

Please note that you may take away our permission at any time in writing, except if we have already acted.

What are your Rights?

You have the right:

- **To ask for a copy of your health and claim records.**
  For a reasonable fee. We may deny your request and you may have it reviewed. You can name someone else to receive.
- **To inspect and correct health and claims records**
  If they are incorrect or incomplete. We may deny your request and will explain in writing.
- **To request confidential communications.**
  For example: to receive mail at a different address. We will accept valid requests. Tell us if you fear that contacts about your health information where you are now would put you in danger.
- **To limit what we use or share for treatment, payment, or our operations or to others.**
  We may deny your request.
- **To a list of those with whom we have shared your information for six years prior to the date you ask except for:**
  - treatment, payment, and health care operations;
  - prior disclosures;
  - sharing done with your agreement;
  - uses for disclosures authorized or required by law.

  We will charge a reasonable fee if you ask for a list more than once in a period of 12 months. You need to make this request in writing.
- **To choose someone to act for you to exercise your rights and make choices**
  By a medical power of attorney or legal guardian. We will verify this authority before we take any action.
- **To be notified of any breach of unsecured medical information**
  Unless we determine that there is a low probability that your medical information has been compromised.

Exercising your Rights

- **Contacting FCC**
  If you have any questions, or to get a paper copy of Florida Community Care's Notice of Privacy Practices, please contact us at:

  Florida Community Care, LLC
  Privacy Officer
  5200 Blue Lagoon Drive, Suite 500
  Miami, FL 33126
  Tel: 1 (833) 322-7526
  Compliance@fcchealthplan.com

You will not be retaliated against for filing a complaint.

Section 3: Getting Help from Our Member Services

Our Member Services Department can answer all of your questions. We can help you choose or change your Primary Care Provider (PCP for short), find out if a service is covered, get referrals, find a provider, replace a lost ID card, report the birth of a new baby, and explain any changes that might affect you or your family's benefits.

Contacting Member Services

You may call us at 1-833-FCC-PLAN, or TTY: 711 Monday to Friday, 8 a.m. to 8 p.m., but not on State approved holidays (like Christmas Day and Thanksgiving Day). When you call, make sure you have your identification card (ID card) with you so we can help you. (If you lose your ID card, or if it is stolen, call Member Services.)

Contacting Member Services after Hours

If you call when we are closed, please leave a message. We will call you back the next business day. If you have an urgent question, you may call our Nurse Hotline at 1-833-FCC-PLAN, or TTY: 711. Our nurses are available to help you 24 hours a day, 7 days a week.

Section 4: Do You Need Help Communicating?

If you do not speak English, we can help. We have people who help us talk to you in your language. We provide this help for free.

For people with disabilities: If you use a wheelchair, or are blind, or have trouble hearing or understanding, call us if you need extra help. We can tell you if a provider's office is wheelchair accessible or has devices for communication. Also, we have services like:

- Telecommunications Relay Service. This helps people who have trouble hearing or talking to make phone calls. Call 711 and give them our Member Services phone number. It is 1-833-FCC-PLAN (1-833-322-7526). They will connect you to us.
- Information and materials in large print, audio (sound); and braille
- Help in making or getting to appointments
- Names and addresses of providers who specialize in your disability

All of these services are provided free to you.

Section 5: When Your Information Changes

If any of your personal information changes, let us know as soon as possible. You can do so by calling Member Services. We need to be able to reach you about your health care needs.

The Department of Children and Families (DCF) needs to know when your name, address, county, or telephone number changes as well. Call DCF toll free at 1-866-762-2237 (TTY 1-800-955-8771) Monday through Friday from 8 a.m. to 5:30 p.m. You can also go online and make the changes in your Automated Community Connection to Economic Self Sufficiency (ACCESS) account at https://dcf-access.dcf.state.fl.us/access/index.do. You may also contact the Social Security Administration (SSA) to report changes. Call SSA toll free at 1-800-772-1213 (TTY 1-800-325-0778), Monday through Friday from 7 a.m. to 7 p.m. You may also contact your local Social Security office or go online and make changes in your *my* Social Security account at https://secure.ssa.gov/RIL/SiView.do.

Section 6: Your Medicaid Eligibility

In order for you to go to your health care appointments and for Florida Community Care to pay for your services, you have to be covered by Medicaid and enrolled in our plan. This is called having Medicaid eligibility. DCF decides if someone qualifies for Medicaid.

Sometimes things in your life might change, and these changes can affect whether or not you can still have Medicaid. It is very important to make sure that you have Medicaid before you go to any appointments. Just because you have a Plan ID Card does not mean that you still have Medicaid. Do not worry! If you think your Medicaid has changed or if you have any questions about your Medicaid, call Member Services and we can help you check on it.

If you Lose your Medicaid Eligibility

If you lose your Medicaid and get it back within 180 days, you will be enrolled back into our plan.

If you have Medicare

If you have Medicare, continue to use your Medicare ID card when you need medical services (like going to the doctor or the hospital), but also give the provider your Medicaid Plan ID card too.

If you are having a baby

If you have a baby, he or she will be automatically covered by an MMA plan on the date of birth. Call Member Services to let us know that your baby has arrived and we will help make sure your baby is covered and has Medicaid right away.

It is helpful if you let us know that you are pregnant before your baby is born to make sure that your baby has Medicaid. Call DCF toll free at 1-866-762-2237 while you are pregnant. If you need help talking to DCF, call us. DCF will make sure your baby has Medicaid from

the day he or she is born. They will give you a Medicaid number for your baby. With DCF, you can also choose an MMA plan for your baby. Let us know the baby's Medicaid number when you get it.

Section 7: Enrollment in Our Plan

When you first join our plan, you have 120 days to try our plan. If you do not like it for any reason, you can enroll in another SMMC plan in this region. Once those 120 days are over, you are enrolled in our plan for the rest of the year. This is called being locked-in to a plan. After being in our plan for one year, you can choose to stay with us or select another plan. This happens every year you have Medicaid and are in the SMMC program.

Open Enrollment

Open enrollment is a period that starts 60 days before the end of your year in our plan. The State's Enrollment Broker will send you a letter letting you know that you can change plans if you want. This is called your **Open Enrollment** period. You do not have to change plans. If you leave our plan and enroll in a new one, you will start with your new plan at the end of your year in our plan. Once you are enrolled in the new plan, you will have another 60 days to decide if you want to stay in that plan or change to a new one before you are locked-in for the year. You can call the Enrollment Broker at 1-877-711-3662 (TDD 1-866-467-4970).

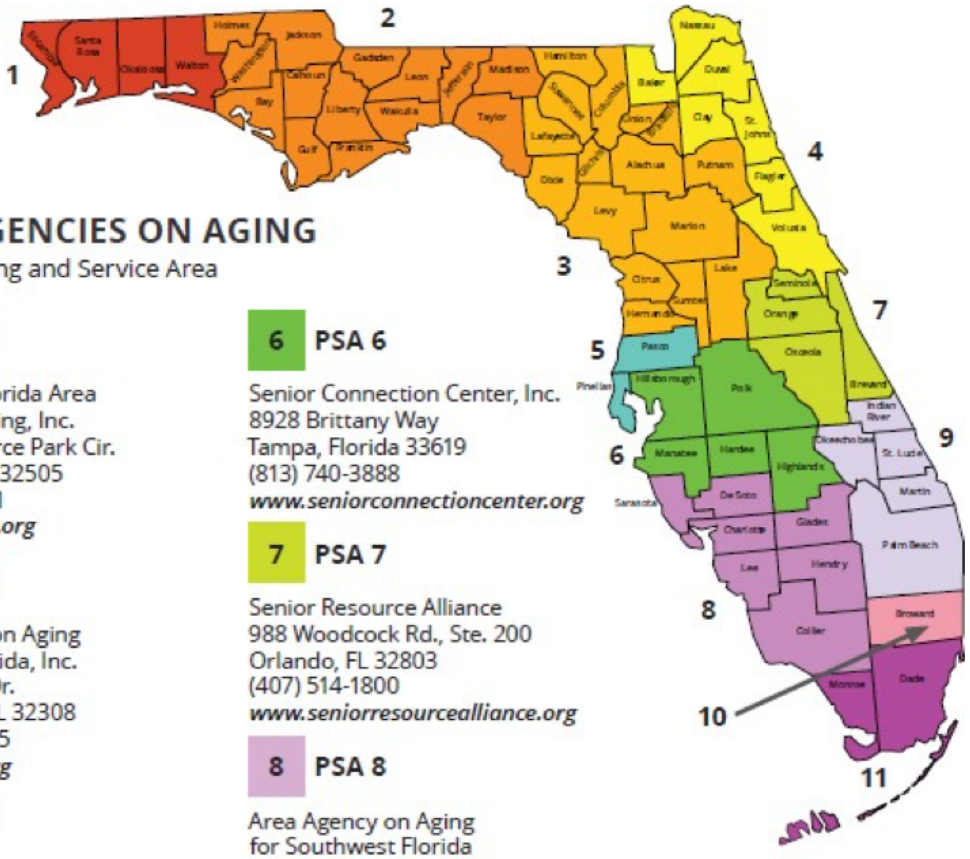
Enrollment in the SMMC Long-term Care Program

The SMMC Long-term Care (LTC) program provides nursing facility services and home and community-based care to elders and adults (ages 18 years and older) with disabilities. Home and community-based services help people stay in their homes, with services like help with bathing, dressing, and eating; help with chores; help with shopping; or supervision.

We pay for services that are provided at the nursing facility. If you live in a Medicaid nursing facility full-time, you are probably already in the LTC program. If you don't know, or don't think you are enrolled in the LTC program, call Member Services. We can help you.

The LTC program also provides help for people living in their home. But space is limited for these in-home services, so before you can receive these services, you have to speak to someone who will ask you questions about your health. This is called a screening. The Department of Elder Affairs' Aging and Disability Resource Centers (ADRC) complete these screenings. Once the screening is complete, your name will go on a waiting list. When you get to the top of the waiting list, the Department of Elder Affairs Comprehensive Assessment and Review for Long- term Care Services (CARES) program will ask you to provide more information about yourself to make sure you meet other medical criteria to receive services from the LTC program. Once you are enrolled in the LTC program, we will make sure you continue to meet requirements for the program each year.

You can find the phone number for your local ADRC using the following map. They can also help answer any other questions that you have about the LTC program.



AREA AGENCIES ON AGING

PSA - Planning and Service Area

1 PSA 1

Northwest Florida Area
Agency on Aging, Inc.
5090 Commerce Park Cir.
Pensacola, FL 32505
(850) 494-7101
www.nwflaaa.org

2 PSA 2

Area Agency on Aging
for North Florida, Inc.
2414 Mahan Dr.
Tallahassee, FL 32308
(850) 488-0055
www.aaanf.org

3 PSA 3

Elder Options
100 SW 75th St., #301
Gainesville, FL 32607
(352) 378-6649
www.agingresources.org

4 PSA 4

ElderSource, The Area Agency
on Aging of Northeast Florida
10688 Old St. Augustine Rd.
Jacksonville, FL 32257
(904) 391-6600
www.myeldersource.org

5 PSA 5

Area Agency on Aging of
Pasco-Pinellas, Inc.
9549 Koger Blvd.
Gadsden Bldg., Ste. 100
St. Petersburg, FL 33702
(727) 570-9696
www.agingcarefl.org

6 PSA 6

Senior Connection Center, Inc.
8928 Brittany Way
Tampa, Florida 33619
(813) 740-3888
www.seniorconnectioncenter.org

7 PSA 7

Senior Resource Alliance
988 Woodcock Rd., Ste. 200
Orlando, FL 32803
(407) 514-1800
www.seniorresourcealliance.org

8 PSA 8

Area Agency on Aging
for Southwest Florida
15201 N Cleveland Ave.
Ste. 1100
North Fort Myers, FL 33903
(239) 652-6900
www.aaaswfl.org

9 PSA 9

Area Agency on Aging of Palm
Beach/Treasure Coast
4400 N Congress Ave.
West Palm Beach, FL 33407
(561) 684-5885
www.youragingresourcecenter.org

10 PSA 10

Aging and Disability Resource
Center of Broward County, Inc.
5300 Hiatus Rd.
Sunrise, FL 33351
(954) 745-9567
www.adrcbroward.org

11 PSA 11

Alliance for Aging, Inc.
760 NW 107th Ave.
Ste. 214, 2nd Floor
Miami, FL 33172
(305) 670-6500
www.allianceforaging.org

County coloring represents area served by the corresponding Area Agency on Aging.

Section 8: Leaving Our Plan (Disenrollment)

Leaving a plan is called **disenrolling**. If you want to leave our plan while you are locked-in, you have to call the State's Enrollment Broker. By law, people cannot leave or change plans while they are locked-in except for very special reasons. The Enrollment Broker will talk to you about why you want to leave the plan. The Enrollment Broker will also let you know if the reason you stated allows you to change plan.

You can leave our plan at any time for the following reasons (also known as **Good Cause Disenrollment** reasons[1]):

- You are getting care at this time from a provider that is not part of our plan but is a part of another Plan
- We do not cover a service for moral or religious reasons
- You are an American Indian or Alaskan Native
- You live in and get your Long-term Care services from an assisted living facility, adult family care home, or nursing facility provider that was in our network but is no longer in our network

You can also leave our plan for the following reasons, if you have completed our grievance and appeal process[2]:

- You receive poor quality of care, and the Agency agrees with you after they have looked at your medical records
- You cannot get the services you need through our plan, but you can get the services you need through another plan
- Your services were delayed without a good reason

If you have any questions about whether you can change plans, call Member Services or the State's Enrollment Broker at 1-877-711-3662 (TDD 1-866-467-4970).

Removal from Our Plan (Involuntary Disenrollment)

The Agency can remove you from our plan (and sometimes the SMMC program entirely) for certain reasons. This is called involuntary disenrollment. These reasons include:

- You lose your Medicaid
- You move outside of where we operate, or outside the State of Florida
- You knowingly use your Plan ID card incorrectly or let someone else use your Plan ID card
- You fake or forge prescriptions

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[1] For the full list of Good Cause Disenrollment reasons, please see Florida Administrative Rule 59G-8.600: https://www.flrules.org/gateway/RuleNo.asp?title=MANAGED CARE&ID=59G-8.600

[2] To learn how to ask for an appeal, please turn to page Section 15, Member Satisfaction, on page 52

- You or your caregivers behave in a way that makes it hard for us to provide you with care
- You are in the LTC program and live in an assisted living facility or adult family care home that is not home-like and you will not move into a facility that is home-like[3]

If the Agency removes you from our plan because you broke the law or for your behavior, you cannot come back to the SMMC program.

Section 9: Managing Your Care

As a member in the LTC Program, we will assign you a case manager who will best suit your needs. Your case manager is your go-to person and is responsible for coordinating your care. This means that they are the person who will help you figure out what LTC services you need and how to get them.

If you have a problem with your care, or something in your life changes, let your case manager know and they will help you decide if your services need to change to better support you.

Changing Case Managers

If you want to choose a different case manager, call Member Services. There may be times when we will have to change your case manager. If we need to do this, we will send a letter to let you know.

Important Things to Tell Your Case Manager

If something changes in your life or you don't like a service or provider, let your case manager know. You should tell your case manager if:

- You don't like a service
- You have concerns about a service provider
- Your services aren't right
- You get new health insurance
- You go to the hospital or emergency room
- Your caregiver can't help you anymore
- Your living situation changes
- Your name, telephone number, address, or county changes

[3] This is for Long-term Care program enrollees only. If you have questions about your facility's compliance with this federal requirement, please call Member Services or your case manager.

Section 10: Accessing Services

Before you get a service or go to a health care appointment, we have to make sure that you need the service and that it is medically right for you. This is called prior authorization. To do this, we look at your medical history and information from your doctor or other health care providers. Then we will decide if that service can help you. We use rules from the Agency to make these decisions.

Providers in Our Plan

For the most part, you must use doctors, hospitals, and other health care providers that are in our provider network. Our provider network is the group of doctors, therapists, hospitals, facilities, and other health care providers that we work with. You can choose from any provider in our provider network. This is called your freedom of choice. If you use a health care provider that is not in our network, you may have to pay for that appointment or service.

You will find a list of providers that are in our network in our provider directory. If you want a copy of the provider directory, call 1-833-FCC-PLAN to get a copy or visit our website at www.fcchealthplan.com.

If you are in the LTC program, your case manager is the person who will help you choose a service provider for each of your services. Once you choose a service provider, they will contact them to begin your services. This is how services are approved in the LTC program. Your case manager will work with you, your family, your caregivers, your doctors and other providers to make sure that your LTC services work with your medical care and other parts of your life.

Providers Not in Our Plan

There are some services that you can get from providers who are not in our provider network. These services are:

- Family planning services and supplies
- Women's preventative health services, such as breast exams, screenings for cervical cancer, and prenatal care
- Treatment of sexually transmitted diseases
- Emergency care

If we cannot find a provider in our provider network for these services, we will help you find another provider that is not in our network. Remember to check with us first before you use a provider that is not in our provider network. If you have questions, call Member Services.

Your dental plan will cover most of your dental services, but some dental services may be covered by your medical plan. The table below will help you to decide which plan pays for a service.

Type of Dental Service	Dental Plan Covers:	Medical Plan Covers:
Dental Services	Covered when you see your dentist or dental hygienist	Covered when you see your doctor or nurse
Scheduled dental services in a hospital or surgery center	Covered for dental services by your dentist	Covered for doctors, nurses, hospitals, and surgery centers
Hospital visit for a dental problem	*Not covered*	Covered
Prescription drugs for a dental visit or problem	*Not covered*	Covered
Transportation to your dental service or appointment	*Not covered*	Covered

What Do I Have to Pay For?

You may have to pay for appointments or services that are not covered. A covered service is a service that we have to provide in the Medicaid program. All of the services listed in this handbook are covered services. Remember, just because a service is covered, does not mean that you will need it. You may have to pay for services if we did not approve it first.

If you get a bill from a provider, call Member Services. Do not pay the bill until you have spoken to us. We will help you.

Services for Children[4]

We must provide all medically necessary services for our members who are ages 18 – 20 years old. This is the law. This is true even if we do not cover a service or the service has a limit. As long as your child's services are medically necessary, services have:

- No dollar limits; or
- No time limits, like hourly or daily limits

Your provider may need to ask us for approval before giving your child the service. Call Member Services if you want to know how to ask for these services.

Moral or Religious Objections

Some providers may not perform some services based on religious or moral beliefs. If this happens, call your case manager at 1-833-FCC-PLAN for help.

[4] Also known as "Early and Periodic Screening, Diagnosis, and Treatment" or "EPSDT" requirements

Section 11: Helpful Information About Your Benefits

Choosing a Primary Care Provider (PCP)

If you have Medicare, please contact the number on your Medicare ID card for information about your PCP. You do not have to change your Medicare PCP to get medical services. You can keep your same Medicare PCP. If you do not have a Medicare PCP, we can help you find one.

If you have Medicaid or MediKids but you do not have Medicare, one of the first things you will need to do when you enroll in our plan is choose a PCP. This can be a doctor, nurse practitioner, or a physician assistant. You will see your PCP for regular check-ups, shots (immunizations), or when you are sick. Your PCP will also help you get care from other providers or specialists. This is called a **referral**. You can choose your PCP by calling Member Services.

You can choose a different PCP for each family member or you can choose one PCP for the entire family. If you do not choose a PCP, we will assign a PCP for you and your family.

You can change your PCP at any time. To change your PCP, call Member Services.

Choosing a PCP for Your Child

You will need to pick a PCP for your baby. You can pick a PCP for your baby before your baby is born. To help you pick a PCP you can speak with a choice counselor by phone. To speak with a choice counselor:

Contact the Statewide Medicaid Managed Care Help Line toll free at 1-877-711-3662; telecommunications device for the deaf (TDD) 1-866-467-4970 or visit the website at www.flmedicaidmanagedcare.com.

It is important that you select a PCP for your child to make sure they get their well child visits each year. Well child visits are for children 0 – 20 years old. These visits are regular check-ups that help you and your child's PCP know what is going on with your child and how they are growing. Your child may also receive shots (immunizations) at these visits. These visits can help find problems and keep your child healthy.[5]

You can take your child to a pediatrician, family practice provider, or other health care provider.

You do not need a referral for well child visits. There is no charge for well child visits.

Specialist Care and Referrals

Sometimes, you may need to see a provider other than your PCP for medical problems like special conditions, injuries, or illnesses. Talk to your PCP first. Your PCP will refer

[5] For more information about the screenings and assessments that are recommended for children, please refer to the "Recommendations for Preventative Pediatric Health Care – Periodicity Schedule" at www.aap.org.

you to a **specialist**. A specialist is a provider who works in one health care area. If you are seeing a network specialist, you do not need to worry about a formal **referral** from your PCP.

If you have a case manager, make sure you tell your case manager about all specialists you are seeing. The case manager will work with the specialist to get you care.

Second Opinions

You have the right to get a second opinion about your care. This means talking to a different provider to see what they have to say about your care. The second provider will give you their point of view. This may help you decide if certain services or treatments are best for you. There is no cost to you to get a second opinion.

Your PCP, case manager or Member Services can help find a provider to give you a second opinion. You can pick any of our providers. If you are unable to find a provider with us, we will help you find a provider that is not in our provider network. If you need to see a provider that is not in our provider network for the second opinion, we must approve it before you see them.

Urgent Care

Urgent Care is not Emergency Care. Urgent Care is needed when you have an injury or illness that must be treated within 48 hours. Your health or life are not usually in danger, but you cannot wait to see your PCP, or it is after your PCP's office has closed.

If you need Urgent Care after office hours and you cannot reach your PCP, call your case manager at 1-833-FCC-PLAN.

You may also find the closest Urgent Care center to you by checking the Florida Community Care online directory. Follow these instructions:

- Select 'Urgent Care' from the Provider Type dropdown
- Select one of the following:
  - by zip code
  - by distance from a zip code
  - by city/county/state
  - no preference
- Enter your zip code, city, county, or state
- Select any other options important to you (i.e.: languages spoken, etc.)
- Select 'Search'

Hospital Care

If you need to go to the hospital for an appointment, surgery or overnight stay, your PCP will set it up. We must approve services in the hospital before you go, except for emergencies. We will not pay for hospital services unless we approve them ahead of time or it is an emergency.

If you have a case manager, they will work with you and your provider to put services in place when you go home from the hospital.

Emergency Care

You have a medical **emergency** when you are so sick or hurt that your life or health is in danger if you do not get medical help right away. Some examples are:

- Broken bones
- Bleeding that will not stop
- You are pregnant, in labor and/or bleeding
- Trouble breathing
- Suddenly unable to see, move, or talk

Emergency services are those services that you get when you are very ill or injured. These services try to keep you alive or to keep you from getting worse. They are usually delivered in an emergency room.

If your condition is severe, call 911 or go to the closest emergency facility right away. You can go to any hospital or emergency facility. If you are not sure if it is an emergency, call your PCP. Your PCP will tell you what to do.

The hospital or facility does not need to be part of our provider network or in our service area. You also do not need to get approval ahead of time to get emergency care or for the services that you receive in an emergency room to treat your condition.

If you have an emergency when you are away from home, get the medical care you need. Be sure to call Member Services when you are able and let us know.

Filling Prescriptions

We cover a full range of prescription medications. We have a list of drugs that we cover. This list is called our **Formulary**. You can find this list on our Web site at www.fcchealthplan.com or by calling Member Services.

We cover **brand name** and **generic** drugs. Generic drugs have the same ingredients as brand name drugs, but they are often cheaper than brand name drugs. They work the same. Sometimes, we may need to approve using a brand name drug before your prescription is filled.

We have pharmacies in our provider network. You can fill your prescription at any pharmacy that is in our provider network. Make sure to bring your Plan ID card with you to the pharmacy.

The list of covered drugs may change from time to time, but we will let you know if anything changes.

Specialty Pharmacy Information:

We cover brand name and generic drugs. Generic drugs have the same ingredients as brand name drugs, but they are often cheaper than brand name drugs. They work the same. Sometimes, we may need to approve using a brand name drug before your prescription is filled. You can fill your first prescription at any network pharmacy that is in our provider network. The pharmacy will arrange to have refills delivered to your place of

residence or a CVS pharmacy that you specify. Make sure to bring your Plan ID card with you to the pharmacy.

The list of covered drugs may change from time to time, but we will let you know if anything changes.

Behavioral Health Services

There are times when you may need to speak to a therapist or counselor if you are having any of the following feelings or problems:

- Always feeling sad
- Not wanting to do the things that you used to enjoy
- Feeling worthless
- Having trouble sleeping
- Not feeling like eating
- Alcohol or drug abuse
- Trouble in your marriage
- Parenting concerns

We cover many different types of behavioral health services that can help with issues you may be facing. You can call a behavioral health provider for an appointment. You can get help finding a behavioral health provider by:

- Calling Florida Community Care at 1-833-FCC-PLAN
- Looking at our provider directory
- Going to our website at www.fcchealthplan.com

Someone is there to help you 24 hours a day, 7 days a week.

You do not need a referral from your PCP for behavioral health services.

If you are thinking about hurting yourself or someone else, call 911. You can also go to the nearest emergency room or crisis stabilization center, even if it is out of our service area. Once you are in a safe place, call your PCP if you can. Follow up with your provider within 24-48 hours. If you get emergency care outside of the service area, we will make plans to transfer you to a hospital or provider that is in our plan's network once you are stable.

Member Reward Programs

We offer programs to help keep you healthy and to help you live a healthier life (like losing weight or quitting smoking). We call these healthy behavior programs. You can earn rewards while participating in these programs. Our plan offers the following programs:

Substance Abuse

The Substance Abuse Program helps you with treatment options. You can get access to psychiatrists, substance abuse professionals, alcohol and substance use programs, and in your neighborhood.

What you have to do	What you Get (Rewards)	Limits on purchase
Be in the program and be active for three months in a row, including Alcoholics Anonymous or Narcotics Anonymous	A $20.00 pre-paid gift card	The card cannot be used for alcohol, tobacco, drugs, and gambling
Be in the program and be active for six months in a row, including Alcoholics Anonymous or Narcotics Anonymous	A $25.00 pre-paid gift card	The card cannot be used for alcohol, tobacco, drugs, and gambling

Smoking Cessation

The Smoking Cessation Program includes counseling and medicines that do not have nicotine to help reach your goals. You can get help to stop smoking.

What you have to do	What you Get (Rewards)	Limits on purchase
Be in the program and be active for three months in a row.	A $20.00 pre-paid gift card	The card cannot be used for alcohol, tobacco, drugs, and gambling
Be in the program and be active for six months in a row.	A $25.00 pre-paid gift card	The card cannot be used for alcohol, tobacco, drugs, and gambling

Weight Loss

The Weight Loss Program includes nutrition counseling over the phone and a diet plan that is overseen by the Medical Director and the Registered/Licensed Dietitian. Florida Community Care's team will help reach your goals. We will also work with your doctors to help you manage your weight.

What you have to do	What you Get (Rewards)	Limits on purchase
Prove that you've lost 5% of your weight	A $20.00 pre-paid gift card	The card cannot be used for alcohol, tobacco, drugs, and gambling
Prove that you've lost 10% of your weight	A $25.00 pre-paid gift card	The card cannot be used for alcohol, tobacco, drugs, and gambling

Please remember that rewards cannot be transferred. If you leave our Plan for more than 180 days, you may not receive your reward. If you have questions or want to join any of these programs, please call us at 1-833-FCC-PLAN.

Disease Management Programs

Our programs for chronic care include educating you about your health conditions. We also help you manage your health, and help you reach your goals.

We have special programs available that will help you if you have one of these conditions.

Cancer

Cancer is a disease in which cells grow and divide with little or no control. There are many types of cancer, they normally are called by the organ or cell where the cancer begins. If you have cancer, we can help you based on your needs.

If you have cancer or are in remission, this program helps to bring together you and your family and caregivers. It helps you deal with frustration, fatigue, pain, isolation, poor sleeping, and living with the unknown. In the program you will learn good exercises. You can also take classes to help you. Times of these classes will be posted on the FCC website for easy access and planning.

The FCC staff will also work closely with your doctors to help you manage the disease and its symptoms.

Contact your case manager at 1-833-FCC-PLAN for more information.

Diabetes

Diabetes is a chronic disease which your body does not make enough insulin or the insulin in your body does not work the way it is supposed to work. This will cause high levels of sugar in your blood. Diabetes worsens with age and with other health conditions that may be present.

Florida Community Care's Diabetes Program has a team of staff hat know how to help people with diabetes.

This includes:

- Education that may help you manage your diabetes and other things to look for
- Review your medicines with your doctors
- Teaching you how important it is to check your blood sugar levels and how to keep track of it
- Support for you and your caregivers
- Diet education and possible referral to a registered dietitian Contact your case manager at 1-833-FCC-PLAN for more information.

Asthma/COPD

Asthma is a disease that causes the inside of the airways to get swollen. It will also make the muscles to get tight. This causes you to get short of breath. It can make you feel

weaker. Asthma is a disease that cannot be cured but it can be managed. This will help you to keep your asthma from getting worse.

COPD can also be known as chronic bronchitis and/or emphysema. Bronchitis is airways get swollen. Emphysema is damage to the air sacs in the lungs. Both can cause shortness of breath.

These can be a problem for you in doing your normal activities. It puts more stress on you or those that take care of you.

We will help you and your family learn more about these diseases. We will work closely with your doctors to manage the disease. This will include the following:

- Education on how to prevent asthma attacks
- Review medicines you are taking at home
- Review medicines with your doctors
- Help to identify the causes of the asthma attack
- Education on how to manage the disease. This is one of the most important points since you and/or your caregiver will learn to manage your disease on a day to day basis.
- Our staff will help provide you with support and for your caregivers. Taking care of stress will help you from getting worse.

With your approval, Florida Community Care staff will refer you to the staff that can help you in managing your Asthma/ COPD.

Contact your case manager at 1-833-FCC-PLAN for more information.

High blood pressure (hypertension)

Hypertension or high blood pressure is when the force of your blood pushing in your arteries is always high. This can cause damage to the walls of the arteries and this can cause other problems. This high force, if always constant, will cause the heart and lungs to work harder than normal. This can cause damage to the heart and lungs.

It is important to lower the force so that the heart and lungs do not work so hard. This can be done by medicine, diet, exercise, less stress, and/or losing weight.

FCC will give you information for your needs. We will work closely with your doctors to help you manage your high blood pressure. This will include the following:

- Education on how to manage your high blood pressure
- Review medicines you are taking at home
- Review medicines with your doctors
- Teaching you about how important it is to check your blood pressure and to keep track of it
- Teaching you about what to eat and not to eat
- Referral, if you need one, to a registered dietician
- We will help provide support to you and your caregivers. Managing stress will help you control your blood pressure.

Florida Community Care staff with the approval of you and/or your caregiver will refer you to the staff you need to get the help you need.

Contact your case manager at 1-833-FCC-PLAN for more information.

Behavioral Health

We offer behavioral health program services through a team of staff who know how to help you with your needs.

We can help you stay out of the hospital. We can help you get services you need in the community. Some of these services may include education for your caregivers. We will talk to you and your caregivers to find out what you know about your condition. We can give you information to help you manage your condition.

You may have issues with stress, depression, anxiety, problems with others, addiction, mood swings, and other issues. Our staff, with behavioral health expertise, will be working together with you and your family to create a plan of care that is right for you. We will work closely with you and your family to find the right provider for you. We have special programs such as for substance abuse and opioid addiction. The FCC staff can talk to you about these programs.

FCC staff will work closely with your doctors. This will include the following:

- Review medicines you are taking at home
- Review medicines with your doctors
- Give you education on symptoms to report and how to control them
- Help you develop a crisis safety plan
- Our staff will help with emotional support to you and your caregivers. Managing stress will help you.

Florida Community Care staff with your approval and/or your caregiver will refer you to our Behavioral Health programs that will meet your needs.

Contact your case manager at 1-833-FCC-PLAN for more information.

End of life issues including information on advance directives

We can help you make decision about your health care. We will give you information about a living will and other documents to help you chose who you want to make decisions for you if you are unable to because you are sick. Contact your case manager at 1-833-FCC-PLAN for more information.

We also offer programs for help with Dementia and Alzheimer's issues

Dementia is loss of mental function that will affect your everyday tasks. It affects memory, and ability to communicate. It is normal for someone to forget where they put their keys.

But, some people with dementia will forget what keys are used for. Dementia can be the cause of some diseases - the most common is Alzheimer's Disease.

Alzheimer's disease is a disease that gets worse with time. Alzheimer's will affect your memory, language, and thought. The exact cause is still not known and there is no cure available now.

It can be difficult for the family and caregivers who take care of those with dementia and/or Alzheimer's. Our Alzbetter Program helps caregivers to develop plans of care just for the enrollee with dementia. It will include tasks and activities that create a good day for the enrollee with things they like to do. Family and caregivers will receive education and training from our staff. Special activities will include puzzles created for people with dementia that match their current levels are just right for them.

We will work closely with your doctors to manage the dementia/Alzheimer's. This will include the following:

- Review medicines you are taking at home
- Reviewing them with your doctors
- Education on how to manage the disease

Florida Community Care staff working with the caregiver and the enrollee will refer to the specialized staff that will help in managing dementia/Alzheimer's.

Contact your case manager at 1-833-FCC-PLAN for more information.

Quality Enhancement Programs

We want you to get quality health care. We offer additional programs that help make the care you receive better. The programs are:

Falls Prevention Program

We know many times a visit to the emergency room is because of a fall. We provide special help to prevent falling. This may include any safety issues at home. Your case manager will talk with you about reasons why. The case manager will with you to ways to prevent a fall. Contact your case manager at 1-833-FCC-PLAN for more information.

End of Life Issues (including information on advance directives)

We can help you make decision about your health care. We will give you information about a living will and other documents to help you chose who you want to make decisions for you if you are unable to because you are sick. Contact your case manager at 1-833-FCC-PLAN for more information.

Domestic Violence

If you are afraid of someone in your house, please tell your case manager. We can help you based on information you give us. We can help you get services that you need to keep you safe and from being afraid. Contact your case manager at 1-833-FCC-PLAN for more information.

Pregnancy Prevention

If you want to keep from getting pregnant, please tell you case manager. We can help you learn more about how to prevent pregnancies. We can give you information about programs that might be right for you. If you would like to know more about how to prevent pregnancies, please contact your case manager at 1-833-FCC-PLAN for more information.

Pregnancy-Related Programs

If you are pregnant or have just given birth, there may be programs helpful to you. We can refer you to those programs. Your case manager will learn more about your situation when they contact you to see how you are doing. If it will help, we can schedule regular home visits by a home health nurse or aide. Contact your case manager at 1-833-FCC-PLAN for more information.

Healthy Start Services

If you are pregnant there are programs that will help you to be sure that you have a healthy baby. Your case manager can learn more about what you may need when they talk with you. We can help you connect with the Healthy Start program in your area. This will help you to make sure you have just the right care so that you and your baby stay healthy. Contact your case manager at 1-833-FCC-PLAN for more information.

Nutritional Assessment/Counseling

If you are pregnant, we can help you with your nutritional needs. We will make sure that you get the information you need based what you tell your case manager. We can help you get services such as with the Women, Infants and Children Nutrition Program (WIC), with Healthy Start or other social services. Contact your case manager at 1-833-FCC-PLAN for more information.

Behavioral Health Programs

We can help you if you are homeless. We can also help you if you are at risk of losing housing, or in the criminal justice system. We will ask questions to help understand any other problems you may be facing. We can connect you to community resources available to you. Contact your case manager at 1-833-FCC-PLAN for more information. You also have a right to tell us about changes you think we should make.

To get more information about our quality enhancement programs or to give us your ideas, call Member Services.

Section 12: Your Plan Benefits: Managed Medical Assistance Services

The table below lists the medical services that are covered by our Plan. Remember, you may need approval from us before you go to an appointment or use a service. Services must be medically necessary in order for us to pay for them.[6]

If you have Original Medicare (Medicare Part A and B), you may choose a PCP to help you get the care you need.

If you have a Medicare Advantage plan, you may need to choose a PCP. For more information, see

https://www.medicare.gov/sign-up-change-plans/medicare-health-plans/medicare-advantage-plans/medicare-advantage-plans-primary-doctor-comparison.html

You can always contact Medicare at 1-800-MEDICARE (TTY 1-877-486-2048) 24 hours a day, seven days a week. You can find out if a doctor accepts Medicare. The Medicare website, www.Medicare.gov, also offers a Physician Compare tool that allows you to find doctors in your area.

There may be some services that we do not cover but might still be covered by Medicaid. To find out about these benefits, call the Agency Medicaid Help Line at 1-877-254-1055. If you need a ride to any of these services, we can help you. You can call 1-833-FCC-PLAN and your case manager will help you schedule a ride.

If there are changes in covered services or other changes that will affect you, we will notify you in writing at least 30 days before the effective date of the change.

If you have Medicare, please use your Medicare ID card when you get medical care (like going to the doctor or the hospital). Also give the provider your Medicaid Plan ID card too.

FCC provides your long-term care. We also cover any medical care you need in case another insurance plan does not. If you have Medicare, you can still see your doctors for Medicare services.

If you have questions about any of the covered medical services, please call Member Services.

Service	Description	Coverage/Limitations	Prior Authorization
Allergy Services	Services to treat conditions such as sneezing or rashes that are not caused by an illness	We cover blood or skin allergy testing and up to 156 doses per year of allergy shots	Yes

[6] You can find the definition for Medical Necessity at http://ahca.myflorida.com/medicaid/review/General/59G_1010_Definitions.pdf

Service	Description	Coverage/Limitations	Prior Authorization
Ambulance Transportation Services	Ambulance services are for when you need emergency care while being transported to the hospital or special support when being transported between facilities	Covered as medically necessary	Yes
Ambulatory detoxification services	Ambulatory setting substance abuse treatment or detoxification services	All enrollees (18 years of age and older 3 hours per day for up to 30 days	Yes
Ambulatory Surgical Center Services	Surgery and other procedures that are performed in a facility that is not the hospital (outpatient)	Covered as medically necessary	Yes
Anesthesia Services	Services to keep you from feeling pain during surgery or other medical procedures	Covered as medically necessary	No
Assistive Care Services	Services provided to adults (ages 18 and older) help with activities of daily living and taking medication	We cover 365/366 days of services per year.	Yes
Behavioral Health Assessment Services	Services used to detect or diagnose mental illnesses and behavioral health disorders	We cover: • One initial assessment per year • One reassessment per year • Up to 150 minutes of brief behavioral health status assessments (no more than 30 minutes in a single day)	Yes

Service	Description	Coverage/Limitations	Prior Authorization
Cardiovascular Services	Services that treat the heart and circulatory (blood vessels) system	We cover the following as prescribed by your doctor: • Cardiac testing • Cardiac surgical procedures • Cardiac devices	Yes
Chiropractic Services	Diagnosis and manipulative treatment of misalignments of the joints, especially the spinal column, which may cause other disorders by affecting the nerves, muscles, and organs	We cover: • One new patient visit • 24 established patient visits per year • X-rays	No
Clinic Services	Health care services provided in a county health department, federally qualified health center, or a rural health clinic	Visit to a federally qualified health center or rural health clinic visit	No
Crisis Stabilization Units and Class III and Class IV Freestanding Psychiatric Hospitals	Inpatient treatment at Crisis Stabilization Unit	All enrollees (18 years of age and older) 365 days for under 21 and 45 days for 21 and older excluding emergency services /Baker Act	Yes; services provided under Baker Act are not subject to prior authorization
Community-Based Wrap-Around services	Community- Based Wrap-Around services	For enrollees 18 years of age to 20 8-10 hours of treatment per week for 2 to 4 months	Yes
Detoxification or Additions Receiving Facilities	Hospital based inpatient detoxification	All enrollees (18 years of age and older) Limit of 365 days for 18 years of age through 20 and 45 days for 21 and older	Yes

Service	Description	Coverage/Limitations	Prior Authorization
Dialysis Services	Medical care, tests, and other treatments for the kidneys. This service also includes dialysis supplies, and other supplies that help treat the kidneys	We cover the following as prescribed by your treating doctor: • Hemodialysis treatments • Peritoneal dialysis treatments	Yes
Drop-In Center	Day care services, per day; mental health program	For enrollees 21 years of age and older Limit of 365 days per year	Yes
Durable Medical Equipment and Medical Supplies Services	Medical equipment is used to manage and treat a condition, illness, or injury. Durable medical equipment is used over and over again, and includes things like wheelchairs, braces, crutches, and other items. Medical supplies are items meant for one-time use and then thrown away	Some service and age limits apply. Call 1-833-FCC-PLAN for more information.	Yes
Emergency Transportation Services	Transportation provided by ambulances or air ambulances (helicopter or airplane) to get you to a hospital because of an emergency	Covered as medically necessary	No

Service	Description	Coverage/Limitations	Prior Authorization
Evaluation and Management Services	Services for doctor's visits to stay healthy and prevent or treat illness	We cover: • One adult health screening (check-up) per year • Well child visits are provided based on age and developmental needs • One visit per month for people living in nursing facilities • Up to two office visits per month for adults to treat illnesses or conditions	No
Family Therapy Services	Services for families to have therapy sessions with a mental health professional	We cover: Up to 26 hours per year	Yes
Gastrointestinal Services	Services to treat conditions, illnesses, or diseases of the stomach or digestion system	Covered as medically necessary	No, except in office procedures
Genitourinary Services	Services to treat conditions, illnesses, or diseases of the genitals or urinary system	Covered as medically necessary	No, except in office procedures
Group Therapy Services	Services for a group of people to have therapy sessions with a mental health professional	We cover: Up to 39 hours per year	Yes
Hearing Services	Hearing tests, treatments and supplies that help diagnose or treat problems with your hearing. This includes hearing aids and repairs	We cover hearing tests and the following as prescribed by your doctor: • Cochlear implants • One new hearing aid per ear, once every 3 years • Repairs	Yes

Service	Description	Coverage/Limitations	Prior Authorization
Home Health Services	Nursing services and medical assistance provided in your home to help you manage or recover from a medical condition, illness or injury	We cover: - Up to 4 visits per day for pregnant recipients and recipients ages 18-20 - Up to 3 visits per day for all other recipients	Yes
Hospice Services	Medical care, treatment, and emotional support services for people with terminal illnesses or who are at the end of their lives to help keep them comfortable and pain free. Support services are also available for family members or caregivers	Covered as medically necessary	Yes
Individual Therapy Services	Services for people to have one-to-one therapy sessions with a mental health professional	We cover: Up to 26 hours per year	Yes
Inpatient Hospital Services	Medical care that you get while you are in the hospital. This can include any tests, medicines, therapies and treatments, visits from doctors and equipment that is used to treat you	We cover the following inpatient hospital services based on age and situation: • Up to 365/366 days for recipients ages Yes, I expected that we would want to do that 18-20 • Up to 45 days for all other recipients (extra days are covered for emergencies)	Yes
Integumentary Services	Services to diagnose or treat skin conditions, illnesses or diseases	Covered as medically necessary	No, except in office procedures

Service	Description	Coverage/Limitations	Prior Authorization
Laboratory Services	Services that test blood, urine, saliva or other items from the body for conditions, illnesses or diseases	Covered as medically necessary	No
Medication Assisted Treatment Services	Services used to help people who are struggling with drug addiction	Covered as medically necessary	Yes
Medication Management Services	Services to help people understand and make the best choices for taking medication	Covered as medically necessary	Yes
Mental Health Partial Hospitalization Program	Mental health partial hospitalization treatment, less than 24 hours	For enrollees 21 years of age and older Up to 30 days annually	Yes
Mental Health Targeted Case Management	Services to help get medical and behavioral health care for people with mental illnesses	Covered as medically necessary	Yes
Mobile Crisis Assessment and Intervention for Enrollees in the Community	Psychiatric health facility service, per day	All enrollees (18 years of age and older) Up to 2 hours per day and 24 hours per year	No
Neurology Services	Services to diagnose or treat conditions, illnesses or diseases of the brain, spinal cord or nervous system	Covered as medically necessary	No, except in office procedures
Non-Emergency Transportation Services	Transportation to and from all of your medical appointments. This could be on the bus, a van that can transport disabled people, a taxi, or other kinds of vehicles	We cover the following services for recipients who have no transportation: • Out-of-state travel • Transfers between hospitals or facilities • Escorts when medically necessary	Yes

Service	Description	Coverage/Limitations	Prior Authorization
Nursing Facility Services	Medical care or nursing care that you get while living full-time in a nursing facility. This can be a short-term rehabilitation stay or long-term; these services can be used instead of going to the hospital in some cases	We cover 365/366 days of services in nursing facilities as medically necessary See information on Patient Responsibility for copayment information	Yes
Occupational Therapy Services	Occupational therapy includes treatments that help you do things in your daily life, like writing, feeding yourself, and using items around the house	We cover for children ages 18-20 and for adults under the $1,500 outpatient services cap: • One initial evaluation per year • Up to 210 minutes of treatment per week • One initial wheelchair evaluation per 5 years We cover for people of all ages: • Follow-up wheelchair evaluations, one at delivery and one 6-months later	Yes
Oral Surgery Services	Services that provide teeth extractions (removals) and to treat other conditions, illnesses or diseases of the mouth and oral cavity	Covered as medically necessary	Yes
Orthopedic Services	Services to diagnose or treat conditions, illnesses or diseases of the bones or joints	Covered as medically necessary	Yes

Service	Description	Coverage/Limitations	Prior Authorization
Outpatient Hospital Services	Medical care that you get while you are in the hospital but are not staying overnight. This can include any tests, medicines, therapies and treatments, visits from doctors and equipment that is used to treat you	Emergency services are covered as medically necessary Non-emergency services cannot cost more than $1,500 per year for recipients ages 21 and over	Yes
Pain Management Services	Treatments for long-lasting pain that does not get better after other services have been provided	Covered as medically necessary. Some service limits may apply	Yes
Partial Hospitalization Services in a Hospital	Psychiatric/ Psychological services; partial hospitalization – less intensive	For enrollees 21 years of age and older Up to 30 days per year	Yes
Physical Therapy Services	Physical therapy includes exercises, stretching and other treatments to help your body get stronger and feel better after an injury, illness or because of a medical condition	We cover for children ages 18-20 and for adults under the $1,500 outpatient services cap: • One initial evaluation per year • Up to 210 minutes of treatment per week • One initial wheelchair evaluation per 5 years We cover for people of all ages: • Follow-up wheelchair evaluations, one at delivery and one 6-months later	Yes

Service	Description	Coverage/Limitations	Prior Authorization
Podiatry Services	Medical care and other treatments for the feet	We cover: • Up to 24 office visits per year • Foot and nail care • X-rays and other imaging for the foot, ankle and lower leg • Surgery on the foot, ankle or lower leg	Yes
Prescribed Drug Services	This service is for drugs that are prescribed to you by a doctor or other health care provider	We cover: • Up to a 34-day supply of drugs, per prescription • Refills, as prescribed	No
Private Duty Nursing Services	Nursing services provided in the home to people ages 0 to 20 who need constant care	We cover: Up to 24 hours per day	Yes
Psychological Testing Services	Tests used to detect or diagnose problems with memory, IQ or other areas	We cover: • 10 hours of psychological testing per year	Yes
Psychosocial Rehabilitation Services	Services to assist people re-enter everyday life. They include help with basic activities such as cooking, managing money and performing household chores	We cover: Up to 480 hours per year	Yes
Radiology and Nuclear Medicine Services	Services that include imaging such as x-rays, MRIs or CAT scans. They also include portable x-rays.	Covered as medically necessary	Yes
Regional Perinatal Intensive Care Center Services	Services provided to pregnant women and newborns in hospitals that have special care centers to handle serious conditions	Covered as medically necessary	Yes

Service	Description	Coverage/Limitations	Prior Authorization
Reproductive Services	Services for women who are pregnant or want to become pregnant. They also include family planning services that provide birth control drugs and supplies to help you plan the size of your family	We cover family planning services. You can get these services and supplies from any Medicaid provider; they do not have to be a part of our Plan. You do not need prior approval for these services. These services are free. These services are voluntary and confidential	Yes
Respiratory Services	Services that treat conditions, illnesses or diseases of the lungs or respiratory system	We cover: • Respiratory testing • Respiratory surgical procedures • Respiratory device management	Yes
Respiratory Therapy Services	Services for recipients ages 0-20 to help you breathe better while being treated for a respiratory condition, illness or disease	We cover: • One initial evaluation per year • One therapy re-evaluation per 6 months • Up to 210 minutes of therapy treatments per week (maximum of 60 minutes per day)	Yes
Self-Help/Peer Services	Self-Help/Peer Services, per 15 minutes	All enrollees (18 years of age and older) 4 hours per day allowed; 40 hours per year	Yes
Specialized Therapeutic Services	Services provided to children ages 18-20 with mental illnesses or substance use disorders	We cover the following: • Assessments • Foster care services • Group home services	Yes

Service	Description	Coverage/Limitations	Prior Authorization
Speech-Language Pathology Services	Services that include tests and treatments help you talk or swallow better	We cover the following services for children ages 18-20: • Communication devices and services • Up to 210 minutes of treatment per week • One initial evaluation per year We cover the following services for adults: • One communication evaluation per 5 years	Yes
Statewide Inpatient Psychiatric Program Services	Services for children with severe mental illnesses that need treatment in the hospital	Covered as medically necessary for children ages 18-20	Yes
Substance Abuse Intensive Outpatient Program	Alcohol and/or drug services; intensive outpatient	All enrollees (18 years of age and older) Daily, up to 4 days per week for 9 weeks	Yes
Substance Abuse Short-Term Residential Treatment	Behavioral health; short- term residential (non- hospital residential treatment program) without room and board	For enrollees 21 years of age and older Up to 30 days per year	Yes
Therapeutic Behavioral On-Site Services	Services provided by a team to prevent children ages 0-20 with mental illnesses or behavioral health issues from being placed in a hospital or other facility	We cover: Up to 9 hours per month	Yes
Transplant Services	Services that include all surgery and pre and post-surgical care	Covered as medically necessary	Yes

Service	Description	Coverage/Limitations	Prior Authorization
Visual Aid Services	Visual Aids are items such as glasses, contact lenses and prosthetic (fake) eyes	We cover the following services when prescribed by your doctor: • Two pairs of eyeglasses for children ages 18-20 • Contact lenses • Prosthetic eyes	Yes
Visual Care Services	Services that test and treat conditions, illnesses and diseases of the eyes	Covered as medically necessary	Yes

American Indian members are not asked to pay copayments.

Your Plan Benefits: Expanded Benefits

Expanded benefits are extra goods or services we provide to you, free of charge. Call Member Services to ask about getting expanded benefits.

Service	Description	Coverage/Limitations	Prior Authorization
Acupuncture	Acupuncture is a form of alternative medicine in which thin needles are used	A professional certified in Acupuncture can provide up to 48 units (15 minutes per unit) per year	Yes
Cell phone services	1 cell phone; 350 minutes; unlimited text messages; 16 GB data	All enrollees eligible If enrollee has no current cell phone. Also, if there is only limited service.	Yes
Chiropractic Services	Diagnosis and manipulative treatment of the joints, especially the spine	Up to 28 more visits	Yes

Service	Description	Coverage/Limitations	Prior Authorization
CVS Discount Program	CVS discount card for a 20% discount for over the counter medicines	All enrollees will receive	No
Durable Medical Equipment/ Supplies	One box fan	For enrollees 21 years of age and older One box fan per year if they do not have air conditioning where they live.	Yes
Hearing Services - expanded	Services to help with hearing loss	For enrollees 21 years of age and older • Assessment for hearing aid • Hearing aid fitting/ checking • Hearing aids Hearing aid evaluation 1 every 2 years; except for a hearing aid in a single in ear, which is 1 per year.	No
Home Delivered Meals – Disaster Preparedness/ Relief	One shelf meal package (10 meals) per disaster	For all enrollees in an affected area with Governor declared state of emergency.	Yes
Housing Assistance	Housing help for when moving from a nursing home to an assisted living facility.	All enrollees eligible (18 years of age and older) $500 per lifetime A list of items is needed.	Yes
Medically Related Home Care Services/ Home Maker	2 carpet cleanings per year	For enrollees 21 years of age and older that a doctor said has a breathing problem called asthma.	Yes

Service	Description	Coverage/Limitations	Prior Authorization
Occupational Therapy	Services to help with pain, gain or bring back physical functioning and movement	For enrollees 21 years of age and older • One evaluation per year • One reevaluation per year • Up to 7 treatment visits per week	Yes
Over the counter (OTC)	• Cough and cold allergy medicines • Vitamins • Medicines for the eyes • Pain medicine • Products for the stomach and bowel • First aid care • Hygiene products • Mosquito spray • Mouth and teeth cleansing products • Skin care	All enrollees eligible (18 years of age and older) Up to $25 per month OTC Catalog	No
Physical Therapy	Services to help with pain, gain or bring back physical functioning and movement	For enrollees 21 years of age and older • One evaluation per year • One reevaluation per year • Up to 7 treatment visits per week	Yes
Prenatal/Perinatal Visits - Expanded	Prenatal and after birth care including breast pumps visits to see doctor during pregnancy and after	For enrollees 18 years of age through 59 • Hospital type breast pump (1 rental per year) • Standard breast pump (1 rental every 2 years) • 14 visits for low-risk pregnancies • 18 visits for high-risk pregnancies • 3 visits within 90 days following delivery	No

Service	Description	Coverage/Limitations	Prior Authorization
Primary Care Services	Well or sick visits to see your PCP	Unlimited office visits	No
Respiratory Therapy	Services to treat problems with the lungs	For enrollees 21 years of age and older • One initial therapy evaluation per year, per enrollee • One respiratory therapy visit, one per day	Yes
Speech Therapy	Services to help with the voice and to talk and swallow	For enrollees 21 years of age and older • Evaluation/ reevaluation, one per year • Evaluation of swallowing, one per year • Speech therapy visit, up to 7 therapy treatment units per week • Augmentative Alternative Communication (AAC) initial evaluation, one per year • AAC reevaluation, one per year • AAC fitting, adjustment, and training visit, up to four 30-minute sessions per year	Yes
Vaccine-Influenza	Flu Vaccine	For enrollees 21 years of age and older Unlimited	No

Service	Description	Coverage/Limitations	Prior Authorization
Vaccine-Shingles	Shingles Vaccine	For enrollees 21 years of age and older One per year	Yes
Vaccine-Pneumonia	Pneumonia Vaccine	For enrollees 21 years of age and older Unlimited	Yes
Vision Services-Expanded	Eye care services that include eye exams	For enrollees 21 years of age and older • Contact lenses – 6-month supply • Eye exam – one per year • Frames – one per year	No
Waived Co-Payments	Members will not need to pay any co-payment charges	No benefit will have a co-payment	No

Section 13: Long-term Care Program Helpful Information

Starting Services

It is important that we learn about you so we can make sure you get the care that you need. Your case manager will set up a time to come to your home or nursing facility to meet you.

At this first visit, you case manager will tell you about the LTC program and our Plan. She or he will also ask you questions about your health, how you take care of yourself, how you spend your time, who helps takes care of you, and other things. These questions make up your **initial assessment**. The initial assessment helps us learn about what you need to live safely in your home. It also helps us decide what services will help you the most.

Developing a Plan of Care

Before you can begin to get services under the LTC program, you have to have a **person-centered plan of care (plan of care)**. Your case manager makes your plan of care. Your plan of care is the document that tells you all about the services you get from our LTC program. Your case manager will talk to you and any family members or caregivers you want to include to decide what LTC services will help. They will use the initial assessment and other information to make a plan that is just for you. Your plan of care will tell you:

- What services you are getting
- Who is providing your service (your service providers)

- How often you get a service
- When a service starts and when it ends (if it has an end date)
- What your services are trying to help you do. For example, if you need help doing small chores around your house, your plan of care will tell you that an adult companion care provider comes 2 days a week to help with your chores.
- How your LTC services work with other services you get from outside our Plan, such as from Medicare, your church or other federal programs
- Your **personal goals**

We don't just want to make sure that you are living safely. We also want to make sure that you are happy and feel connected to your community and other people. When your case manager is making your plan of care, they will ask you about any **personal goals** you might have. These can be anything, really, but we want to make sure that your LTC services help you accomplish your goals. Some examples of personal goals include:

- Walking for 10 minutes every day
- Calling a loved one once a week
- Going to the senior center once a week
- Moving from a nursing facility to an assisted living facility

You or your **authorized representative** (someone you trust who is allowed to talk to us about your care) must sign your plan of care. This is how you show you agree with the Plan and the services we decided.

Your case manager will send your PCP a copy of your plan of care. They will also share it with your other health care providers.

Updating your Plan of Care

Every month your case manager will call you to see how your services are going and how you are doing. If any changes are made, she or he will update your plan of care and get you a new copy.

Your case manager will come to see you in person to review your plan of care every 3 months. This is a good time to talk to them about your services, what is working and isn't working for you, and how your goals are going. They will update your plan of care with any changes. Every time your plan of care changes, you or your authorized representative must sign it.

Remember, you can call your case manager any time to talk about problems you have, changes in your life, or other things. Your case manager is available to you when you need them.

Your Back-Up Plan

Your case manager will help you make a back-up plan. A back-up plan tells you what to do if a service provider does not show up to give a service. For example, your home health aide did not come to give you a bath.

Remember, if you have any problems getting your services, call your case manager.

Section 14: Your Plan Benefits: Long-term Care Services

The table below lists the long-term care services covered by our Plan. Remember, services must be medically necessary in order for us to pay for them.[7]

If there are changes in covered services or other changes that will affect you, we will notify you in writing at least 30 days before the effective date of the change.

If you have any questions about any of the covered long-term care services, please call your case manager or Member Services.

Service	Description	Prior Authorization
Companion Care	This service helps you fix meals, do laundry and light housekeeping	Contact your case manager to update your plan of care
Adult Day Health Care	Supervision, social programs, and activities provided at an adult day care center during the day. If you are there during mealtimes, you can eat there.	Contact your case manager to update your plan of care
Assistive Care Services	These are 24-hour services if you live in an adult family care home or an assisted living facility	Contact your case manager to update your plan of care
Assisted Living	These are services that are usually provided in an assisted living facility. Services can include housekeeping, help with bathing, dressing, and eating, medication assistance, and social programs.	Contact your case manager to update your plan of care
Attendant Nursing Care	Nursing services and medical assistance provided in your home to help you manage or recover from a medical condition, illness, or injury	Contact your case manager to update your plan of care
Behavioral Management	Services for mental health or substance abuse needs	Contact your case manager to update your plan of care
Caregiver Training	Training and counseling for the people who help take care of you	Contact your case manager to update your plan of care

[7] You can find a copy of the Statewide Medicaid Managed Care Long-term Care Program Coverage Policy at http://ahca.myflorida.com/medicaid/review/Specific/59G-4.192_LTC_Program_Policy.pdf

Service	Description	Prior Authorization
Care Coordination/Case Management	Services that help you get the services and support you need to live safely and independently. This includes having a case manager and making a plan of care that lists all the services you need and receive.	Contact your case manager to update your plan of care
Home Accessibility/ Adaptation Services	This service makes changes to your home to help you live and move in your home safely and more easily. It can include changes like installing grab bars in your bathroom or a special toilet seat. It does not include major changes like new carpeting, roof repairs, plumbing systems, etc.	Contact your case manager to update your plan of care
Home Delivered Meals	This service delivers healthy meals to your home	Contact your case manager to update your plan of care
Homemaker Services	This service helps you with general household activities, like meal preparation and routine home chores	Contact your case manager to update your plan of care
Hospice	Medical care, treatment, and emotional support services for people with terminal illnesses or who are at the end of their lives to help keep them comfortable and pain free. Support services are also available for family members or caregivers.	Contact your case manager to update your plan of care
Intermittent and Skilled Nursing	Extra nursing help if you do not need nursing supervision all the time or need it at a regular time	Contact your case manager to update your plan of care

Service	Description	Prior Authorization
Medical Equipment and Supplies	Medical equipment is used to help manage and treat a condition, illness, or injury. Medical equipment is used over and over again, and includes things like wheelchairs, braces, walkers, and other items. Medical supplies are used to treat and manage conditions, illnesses, or injury. Medical supplies include things that are used and then thrown away, like bandages, gloves, and other items.	Contact your case manager to update your plan of care
Medication Administration	Help taking medications if you can't take medication by yourself	Contact your case manager to update your plan of care
Medication Management	A review of all of the prescription and over-the- counter medications you are taking	Contact your case manager to update your plan of care
Nutritional Assessment/Risk Reduction Services	Education and support for you and your family or caregiver about your diet and the foods you need to eat to stay healthy	Contact your case manager to update your plan of care
Nursing Facility Services	Nursing facility services include medical supervision, 24-hour nursing care, help with day- to-day activities, physical therapy, occupational therapy, and speech-language pathology	Contact your case manager to update your plan of care
Personal Care	These are in-home services to help you with: • Bathing • Dressing • Eating • Personal Hygiene	Contact your case manager to update your plan of care
Personal Emergency Response Systems (PERS)	An electronic device that you can wear or keep near you that lets you call for emergency help anytime	Contact your case manager to update your plan of care

Service	Description	Prior Authorization
Respite Care	This service lets your caregivers take a short break. You can use this service in your home, an Assisted Living Facility or a Nursing Home.	Contact your case manager to update your plan of care
Occupational Therapy	Occupational therapy includes treatments that help you do things in your daily life, like writing, feeding yourself, and using items around the house	Contact your case manager to update your plan of care
Physical Therapy	Physical therapy includes exercises, stretching, and other treatments to help your body get stronger and feel better after an injury, illness, or because of a medical condition	Contact your case manager to update your plan of care
Respiratory Therapy	Respiratory therapy includes treatments that help you breathe better	Contact your case manager to update your plan of care
Speech Therapy	Speech therapy includes tests and treatments that help you talk or swallow	Contact your case manager to update your plan of care
Transportation	Transportation to and from all of your LTC program services. This could be on the bus, a van that can transport disabled people, a taxi, or other kinds of vehicles.	Contact your case manager to update your plan of care

Long-term Care Participant Direction Option

You may be offered the Participant Direction Option (PDO). You can use PDO if you use any of these services and live in your home:

- Attendant care services
- Homemaker services
- Personal Care services
- Adult companion care services
- Intermittent and skilled nursing care services

PDO lets you **self-direct** your services. This means you get to choose your service provider and how and when you get your service. You have to hire, train, and supervise the people who work for you (your direct service workers).

You can hire family members, neighbors, or friends. You will work with a case manager who can help you with PDO.

If you are interested in PDO, ask your case manager for more details. You can also ask for a copy of the PDO Guidelines to read and help you decide if this option is the right choice for you.

Your Plan Benefits: LTC Expanded Benefits

Expanded benefits are extra services we provide to you at no cost. Talk to your case manager about getting expanded benefits.

Service	Description	Coverage/ Limitations	Prior Authorization
Assisted Living Facility/Adult Family Care Home – Bed Hold Days	Bed will be held while away sick at a hospital or rehab place.	All enrollees eligible (18 years of age and older) Up to 30 bed hold days per month if requested	Yes
Transition Assistance– Nursing Facility to Community Setting	Pays for certain expenses if an enrollee moves from a nursing home to the community	All enrollees eligible (18 years of age and older) $5,000 per lifetime; A list of items or services is needed	Yes

Section 15: Member Satisfaction

Complaints, Grievances, and Plan Appeals

We want you to be happy with us and the care you receive from our providers. Let us know right away if at any time you are not happy with anything about us or our providers. This includes if you do not agree with a decision we have made.

	What You Can Do:	What We Will Do:
If you are not happy with us or our providers, you can file a **Complaint**	You can: • Call us at any time. 1-833-FCC-PLAN	We will: • Try to solve your issue within 1 business day.

	What You Can Do:	What We Will Do:
If you are not happy with us or our providers, you can file a **Grievance**	You can: • Write us or call us at any time. • Call us to ask for more time to solve your grievance if you think more time will help. Florida Community Care Attn: Grievances and Appeals 5200 Blue Lagoon Drive Suite 500 Miami, FL 33126 1-833-FCC-PLAN	We will: • Review your grievance and send you a letter with our decision within 90 days. If we need more time to solve your grievance, we will: • Send you a letter with our reason and tell you about your rights if you disagree.
If you do not agree with a decision we made about your services, you can ask for an **Appeal**	You can: • Write us, or call us and follow up in writing, within 60 days of our decision about your services. • Ask for your services to continue within 10 days of receiving our letter, if needed. Some rules may apply. Florida Community Care Attn: Grievances and Appeals 5200 Blue Lagoon Drive Suite 500 Miami, FL 33126 1-833-FCC-PLAN	We will: • Send you a letter within 5 business days to tell you we received your appeal. • Help you complete any forms. • Review your appeal and send you a letter within 30 days to answer you.

	What You Can Do:	What We Will Do:
If you think waiting for 30 days will put your health in danger, you can ask for an **Expedited or "Fast" Appeal**	You can: • Write us or call us within 60 days of our decision about your services. Florida Community Care Attn: Grievances and Appeals 5200 Blue Lagoon Drive Suite 500 Miami, FL 33126 1-833-FCC-PLAN	We will: • Give you an answer within 48 hours after we receive your request. • Call you the same day if we do not agree that you need a fast appeal and send you a letter within 2 days.
If you do not agree with our appeal decision, you can ask for a **Medicaid Fair Hearing**	You can: • Write to the Agency for Health Care Administration Office of Fair Hearings. • Ask us for a copy of your medical record. • Ask for your services to continue within 10 days of receiving our letter, if needed. Some rules may apply. ***You must finish the appeal process before you can have a Medicaid Fair Hearing.*	We will: • Provide you with transportation to the Medicaid Fair Hearing, if needed. • Restart your services if the State agrees with you. If you continued your services, we may ask you to pay for the services if the final decision is not in your favor.

Fast Plan Appeal

If we deny your request for a fast appeal, we will transfer your appeal into the regular appeal time frame of 30 days. If you disagree with our decision not to give you a fast appeal, you can call us to file a grievance.

Medicaid Fair Hearings (for Medicaid Members)

You may ask for a fair hearing at any time up to 120 days after you get a Notice of Plan Appeal Resolution by calling or writing to:

Agency for Health Care Administration Medicaid Fair Hearing Unit
P.O. Box 60127
Ft. Meyers, FL 33906
1-877-254-1055 (toll-free)
1-239-338-2642 (fax)
MedicaidFairHearingUnit@ahca.myflorida.com

If you request a fair hearing in writing, please include the following information:

- Your name
- Your member number
- Your Medicaid ID number
- A phone number where you or your representative can be reached

You may also include the following information, if you have it:

- Why you think the decision should be changed
- Any medical information to support the request
- Who you would like to help with your fair hearing

After getting your fair hearing request, the Agency will tell you in writing that they got your fair hearing request. A hearing officer who works for the State will review the decision we made.

Continuation of Benefits for Medicaid Members

If you are now getting a service that is going to be reduced, suspended or terminated, you have the right to keep getting those services until a final decision is made for your **Plan appeal or Medicaid fair hearing**. If your services are continued, there will be no change in your services until a final decision is made.

If your services are continued and our decision is not in your favor, we may ask that you pay for the cost of those services. We will not take away your Medicaid benefits. We cannot ask your family or legal representative to pay for the services.

To have your services continue during your appeal or fair hearing, you must file your appeal and ask to continue services within this timeframe, whichever is later:

- 10 days after you receive a Notice of Adverse Benefits Determination (NABD), or
- On or before the first day that your services will be reduced, suspended or terminated

Section 16: Your Member Rights

As a recipient of Medicaid and a member in a Plan, you also have certain rights. You have the right to:

- Be treated with courtesy and respect
- Have your dignity and privacy respected at all times
- Receive a quick and useful response to your questions and requests
- Know who is providing medical services and who is responsible for your care
- Know what member services are available, including whether an interpreter is available if you do not speak English
- Know what rules and laws apply to your conduct

- Be given information about your diagnosis, the treatment you need, choices of treatments, risks, and how these treatments will help you
- Say no any treatment, except as otherwise provided by law
- Be given full information about other ways to help pay for your health care
- Know if the provider or facility accepts the Medicare assignment rate
- To be told prior to getting a service how much it may cost you
- Get a copy of a bill and have the charges explained to you
- Get medical treatment or special help for people with disabilities, regardless of race, national origin, religion, handicap, or source of payment
- Receive treatment for any health emergency that will get worse if you do not get treatment
- Know if medical treatment is for experimental research and to say yes or no to participating in such research
- Make a complaint when your rights are not respected
- Ask for another doctor when you do not agree with your doctor (second medical opinion)
- Get a copy of your medical record and ask to have information added or corrected in your record, if needed
- Have your medical records kept private and shared only when required by law or with your approval
- Decide how you want medical decisions made if you can't make them yourself (advanced directive)
- To file a grievance about any matter other than a Plan's decision about your services.
- To appeal a Plan's decision about your services
- Receive services from a provider that is not part of our Plan (out-of-network) if we cannot find a provider for you that is part of our Plan.
- Get care without fear of restraint or seclusion used for bullying, discipline, convenience, or revenge
- Exercise these rights without changing the way Florida Community Care or its network providers treat you

LTC Members have the right to:

- Receive services in a home-like environment regardless where you live
- Receive information about being involved in your community, setting personal goals and how you can participate in that process
- Be told where, when and how to get the services you need
- To be able to take part in decisions about your health care.
- To talk openly about the treatment options for your conditions, regardless of cost or benefit
- To choose the programs you participate in and the providers that give you care

Section 17: Your Member Responsibilities

As a recipient of Medicaid and a member in a Plan, you also have certain responsibilities. You have the responsibility to:

- Give accurate information about your health to your Plan and providers
- Tell your provider about unexpected changes in your health condition
- Talk to your provider to make sure you understand a course of action and what is expected of you
- Listen to your provider, follow instructions and ask questions
- Keep your appointments or notify your provider if you will not be able to keep an appointment
- Be responsible for your actions if treatment is refused or if you do not follow the health care provider's instructions
- Make sure payment is made for non-covered services you receive
- Follow health care facility conduct rules and regulations
- Treat health care staff with respect
- Tell us if you have problems with any health care staff
- Use the emergency room only for real emergencies
- Notify your case manager if you have a change in information (address, phone number, etc.)
- Have a plan for emergencies and access this plan if necessary, for your safety
- Report fraud, abuse and overpayment

LTC Members have the responsibility to:

- Tell your case manager if you want to disenroll from the Long-term Care program
- Agree to and participate in the annual face-to-face assessment, quarterly face-to-face visits and monthly telephone contact with your case manager

Section 18: Other Important Information

Patient Responsibility

You have to pay for the patient responsibility when you live in a facility, like an assisted living facility or adult family care home. Patient responsibility is the money you must pay towards the cost of your care. DCF will tell you the amount of your patient responsibility. Patient responsibility is based on your income and will change if your income changes.

Emergency Disaster Plan

Disasters can happen at any time. To protect yourself and your family, it is important to be prepared. There are three steps to preparing for a disaster: 1) Be informed; 2) Make a Plan and 3) Get a Kit. For help with your emergency disaster plan, call Member Services or your case manager. The Florida Division of Emergency Management can also help

you with your plan. You can call them at 1-850-413-9969 or visit their website at www.floridadisaster.org

Fraud/Abuse/Overpayment in the Medicaid Program

To report suspected fraud and/or abuse in Florida Medicaid, call the Consumer Complaint Hotline toll-free at 1-888-419-3456 or complete a Medicaid Fraud and Abuse Complaint Form, which is available online at:

https://apps.ahca.myflorida.com/mpi-complaintform/

You can also report fraud and abuse to us directly by using the following methods:

- Hotline: 1 (866) 409-8031. The Hotline is a telephone line and voice mailbox that can be used 24 hours a day, 7 days a week. This number is confidential and has no caller ID. Please give as much information as possible. Please include the first and last names of the anyone involved. This could include employees, providers; and subcontractor involved.
- In Writing: A report may be made in writing by filling out the Compliance Referral Form. It is located on our website at www.fcchealthplan.com. The Compliance Referral Form may be mailed or faxed.

  Florida Community Care Attn: Compliance Department
  5200 Blue Lagoon Drive, Suite 500
  Miami, FL 33126
  Fax: 1-305-675-5934

- E-mail: A report may be made by sending an email to Florida Community Care. Compliance@fcchealthplan.com

Abuse/Neglect/Exploitation of People

You should never be treated badly. It is never okay for someone to hit you or make you feel afraid. You can talk to your PCP or case manager about your feelings.

If you feel that you are being mistreated or neglected, you can call the Abuse Hotline at 1-800-96-ABUSE (1-800-962-2873) or for TTY/TDD at 1- 800-955-8771.

You can also call the hotline if you know of someone else that is being mistreated. Domestic Violence is also abuse. Here are some safety tips:

- If you are hurt, call your PCP
- If you need emergency care, call 911 or go to the nearest hospital. For more information, see the section called EMERGENCY CARE
- Have a plan to get to a safe place (a friend's or relative's home)
- Pack a small bag, give it to a friend to keep for you

If you have questions or need help, please call the National Domestic Violence Hotline toll free at 1-800-799-7233 (TTY 1-800-787-3224).

Advance Directives

An **advance directive** is a written or spoken statement about how you want medical decisions made if you can't make them yourself. Some people make advance directives when they get very sick or are at the end of their lives. Other people make advance directives when they are healthy. You can change your mind and these documents at any time. We can help you understand or get these documents. They do not change your right to quality health care benefits. The only purpose is to let others know what you want if you can't speak for yourself.

- A Living Will
- Health Care Surrogate Designation
- An Anatomical (organ or tissue) Donation

You can download an advanced directive form from this website: http://www.floridahealthfinder.gov/reports-guides/advance-directives.aspx.

Make sure that someone, like your PCP, lawyer, family member, or case manager knows that you have an advance directive and where it is located.

If there are any changes in the law about advance directives, we will let you know within 90 days. You don't have to have an advance directive if you do not want one.

If your provider is not following your advance directive, you can file a complaint with Member Services at 1-833-FCC-PLAN or the Agency by calling 1-888-419-3456.

Getting More Information

You have a right to ask for information. Call Member Services or talk to your case manager about what kinds of information you can receive for free. Some examples are:

- Your member record
- A description of how we operate
- Florida Community Care's HEDIS Results, as available
- Member educational materials
- Hard-copy member handbook
- Hard-copy provider directory
- The criteria used in making any adverse benefit determinations
- And more

Section 19: Additional Resources

Floridahealthfinder.gov

The Agency is committed to its mission of providing "Better Health Care for All Floridians". The Agency has created a website www.FloridaHealthFinder.gov where you can view information about Florida home health agencies, nursing homes, assisted living facilities, ambulatory surgery centers and hospitals. You can find the following types of information on the website:

- Up-to-date licensure information
- Inspection reports
- Legal actions
- Health outcomes
- Pricing
- Performance measures
- Consumer education brochures
- Living wills
- Quality performance ratings, including member satisfaction survey results

The Agency collects information from all Plans on different performance measures about the quality of care provided by the Plans. The measures allow the public to understand how well Plans meet the needs of their members. To see the Plan report cards, please visit http://www.floridahealthfinder.gov/HealthPlans/search.aspx. You may choose to view the information by each Plan or all Plans at once.

Elder Housing Unit

The Elder Housing Unit provides information and technical assistance to elders and community leaders about affordable housing and assisted living choices. The Florida Department of Elder Affairs maintains a website for information about assisted living facilities, adult family care homes, adult day care centers and nursing homes at http://elderaffairs.state.fl.us/doea/housing.php as well as links to additional Federal and State resources.

Aging and Disability Resource Center

You can also find additional information and assistance on State and federal benefits, local programs and services, legal and crime prevention services, income planning or educational opportunities by contacting the Aging and Disability Resource Center.

Independent Consumer Support Program

The Florida Department of Elder Affairs also offers an Independent Consumer Support Program (ICSP). The ISCP works with the Statewide Long-term Care Ombudsman Program, the ADRC and the Agency to ensure that LTC members have many ways to get information and help when needed.

For more information, please call the Elder Helpline at 1-800-96-ELDER (1-800-963-5337) or visit http://elderaffairs.state.fl.us/doea/smmcltc.php.

Section 20: Forms

At the end of this handbook, we have included the following forms to help you:

- Health Care Advance Directives Wallet Card
- Uniform Donor Form
- Designation of Health Care Surrogate Form
- Living Will Form
- Authorized Representative Form
- Written Request to Appeal Form
- Change of Address Form

These forms can also be found on our website at www.fcchealthplan.com. If you need help with these forms or need other forms, call your case manager at 1-833-FCC-PLAN.

Once filled in, be sure to keep a copy for yourself. Provide a copy to your PCP and your caregivers. Provide a copy to your Florida Community Care case manager.

Health Care Advance Directives

I,_____
have created the following Advance Directives:

___ Living Will

___ Health Care Surrogate Designation

___ Anatomical Donation

___ Other (specify) _____

---------- FOLD ----------

Contact:

Name _____

Address _____

_____

_____

Phone _____

Signature_____Date _____

FLORIDA COMMUNITY CARE

Uniform Donor Form

The undersigned hereby makes this anatomical gift, if medically acceptable, to take effect on death. The words and marks below indicate my desires:

I give:

(a) _____any needed organs or parts

(b) _____only the following organs or parts for the purpose of transplantation, therapy, medical research, or education:

_____

_____

_____

(c) _____ my body for anatomical study if needed. Limitations or special wishes, if any:

_____

_____

_____

Signed by the donor and the following witnesses in the presence of each other:

Donor's Signature _____ Donor's Date of Birth _____

Date Signed _____ City and State _____

Witness _____

Street Address _____

City _____State _____

Witness _____

Street Address _____

City _____State _____

You can use this form to indicate your choice to be an organ donor. Or you can designate it on your driver's license or state identification card (at your nearest driver's license office).

Suggested form of a Health Care Surrogate, Florida Statutes Section 765.203

Designation of Health Care Surrogate

Name _____

In the event I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate, as my surrogate for health care decisions:

Name _____

Street Address _____

City_____ State _____ Zip_____

Phone _____

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my alternate surrogate:

Name _____

Street Address _____

City_____ State _____ Zip_____

Phone _____

I fully understand that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on my behalf; or apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility

Additional Instructions (optional):

I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility. I will notify and send a copy of this document to the following persons other than my surrogate, so they may know who my surrogate is.

Name _____

Name _____

Signed: _____

Witnesses 1. _____

2. _____

At least one witness must not be a husband or wife or a blood relative of the principal.

- This form offered as a courtesy of The Florida Bar and the Florida Medical Association-

LIVING WILLS AND HEALTH CARE ADVANCE DIRECTIVES: FAQs

The Florida Legislature has recognized that every competent adult has the fundamental right of self? determination regarding decisions pertaining to his or her own health, including the right to choose or refuse medical treatment or procedures which would only prolong life when a terminal condition exists. This right, however, is subject to certain interests of society, such as the protection of human life and the preservation of ethical standards in the medical profession. To ensure that this right is not lost or diminished by virtue of later physical or mental incapacity, the Legislature has established a procedure within Florida Statutes Chapter 765 allowing a person to plan for incapacity, and if desired, to designate another person to act on his or her behalf and make necessary medical decisions upon such incapacity.

What is a Living Will?

Every competent adult has the right to make a written declaration commonly known as a "Living Will." The purpose of this document is to direct the provision, the withholding or withdrawal of life prolonging procedures in the event one should have a terminal condition. The suggested form of this instrument has been provided by the Legislature within Florida Statutes Section 765.303. In Florida, the definition of "life prolonging procedures" has been expanded by the Legislature to include the provision of food and water to terminally ill patients.

What is the difference between a Living Will and a legal will?

A Living Will should not be confused with a person's legal will, which disposes of personal property on or after his or her death and appoints a personal representative or revokes or revises another will.

How do I make my Living Will effective?

Under Florida law, a Living Will must be signed by its maker in the presence of two witnesses, at least one of whom is neither the spouse nor a blood relative of the maker. If the maker is physically unable to sign the Living Will, one of the witnesses can sign in the presence and at the direction of the maker. Florida will recognize a Living Will, which has been signed in another state, if that Living Will was signed in compliance with the laws of that state, or in compliance with the laws of Florida.

After I sign a Living Will, what is next?

Once a Living Will has been signed, it is the maker's responsibility to provide notification to the physician of its existence. It is a good idea to provide a copy of the Living Will to the maker's physician and hospital, to be placed within the medical records.

What is a Health Care Surrogate?

Any competent adult may also designate authority to a Health Care Surrogate to make all health care decisions during any period of incapacity. During the maker's incapacity, the Health Care Surrogate has the duty to consult expeditiously , with appropriate health

care providers. The Surrogate also provides informed consent and makes only health care decisions for the maker, which he or she believes the maker would have made under the circumstances if the maker were capable of making such decisions. If there is no indication of what the maker would have chosen, the Surrogate may consider the maker's best interest in deciding on a course of treatment. The suggested form of this instrument has been provided by the Legislature within Florida Statutes Section 765.203.

How do I designate a Health Care Surrogate?

Under Florida law, designation of a Health Care Surrogate should be made through a written document and should be signed in the presence of two witnesses, at least one of whom is neither the spouse nor a blood relative of the maker. The person designated as Surrogate cannot act as a witness to the signing of the document.

Can I have more than one Health Care Surrogate?

The maker can also explicitly designate an Alternate Surrogate. The Alternate Surrogate may assume the duties as Surrogate if the original Surrogate is unwilling or unable to perform his or her duties. If the maker is physically unable to sign the designation, he or she may, in the presence of witnesses, direct that another person sign the document. An exact copy of the designation must be provided to the Health Care Surrogate. Unless the designation states a time of termination, the designation will remain in effect until revoked by its maker.

Can the Living Will and the Health Care Surrogate designation be revoked?

Both the Living Will and the Designation of Health Care Surrogate may be revoked by the maker at any time by a signed and dated letter of revocation; by physically canceling or destroying the original document; by an oral expression of one's intent to revoke; or by means of a later executed document which is materially different from the former document. It is very important to tell the attending physician that the Living Will and Designation of Health Care Surrogate has been revoked.

Where can I go to obtain legal advice on this issue?

If you believe you need legal advice, call your attorney. If you do not have an attorney, call The Florida Bar Lawyer Referral Service at 1-800-342-8011, or the local lawyer referral service or legal aid office listed in the yellow pages of your telephone book.

This information has been prepared by the Consumer Protection Law Committee of The Florida Bar and the Bar's Public Information Office and is offered as a courtesy of The Florida Bar and the Florida Medical Association.

FLORIDA COMMUNITY CARE

LIVING WILL

Declaration made this _____ day of_____, (20_____), I _____, willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if at any time I am incapacitated and:

_____(initial) I have a terminal condition, or

_____ (initial) I have an end stage condition, or

_____ (initial) I am in a persistent vegetative state, and if my primary physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such a condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

In the event that I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the provisions of this declaration:

Name:_____

Address: _____

_____

Phone: _____

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Additional Instructions (optional): _____

_____

_____

Witness Signatures:

Signature _____ Signature _____

Printed Name _____ Printed Name _____

Address _____ Address _____

Phone _____ Phone _____

Florida Community Care LLC
P.O. Box 261060
Miami, Florida 33126

PLAN ID:	

APPOINTMENT OF REPRESENTATIVE

I would like the following person to speak for me in my appeal of denied health services:

Name of Representative:	
Relationship to Enrollee:	
Contact Information:	
Mailing Address:	
Phone:	
Email:	
Signature of Representative:	
Date:	

I know that this person will have rights to my health records and all records related to this appeal. I understand this person will speak for me during the appeal process. This form will expire at the end of the appeal process.

Signature of Enrollee:	
Date:	
Member ID:	
Enrollee Name:	
Mailing Address:	
Phone:	
Email:	

To be completed by FCC:

Appeal Number:	
Date of Receipt of Appeal:	

If you need help filling out forms, please call us. We can help with an interpreter that speaks your language. If you have questions, call us at 833-FCC-PLAN or 711 for TTY. For more information on your rights, review the Grievance and Appeal section in your Member Handbook. It can be found online at: www.fcchealthplan.com.

Florida Community Care LLC
P.O. Box 261060
Miami, Florida 33126

This information is available for free in other languages. Please contact our customer service number at 1-833-FCC-PLAN (1-833-322-7526) (TDD/TTY 711) between the hours of 8 AM and 8 PM.

Esta información está disponible gratis en otros idiomas. Por favor, póngase en contacto con nuestro número de Servicios para Miembros a 1-833-FCC-PLAN (1-833-322-7526 (TDD/TTY 711), de lunes a Viernes, de 8 a.m. a 8 p.m.

Enfòmasyon sa a disponib gratis nan lòt lang. Tanpri kontakte sèvis kliyantèl nou an nan nimewo 1-833-FCC-PLAN (1-833-322-7526 (TDD/TTY 711) soti lendi pou rive vandredi, depi 8è AM rive 8è PM.

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Florida Community Care:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides 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, contact Enrollee Services.

If you believe that Florida Community Care has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Enrollee Services, 833-FCC-PLAN (833-322-7526) or 711 for TTY.

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

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-997-0979 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-888-997-0979 (TTY: 711).

CHÚ ?: N?u b?n nói Ti?ng Vi?t, có các d?ch v? h? tr? ngôn ng? mi?n phí dành cho b?n. G?i s? 1-888-997-0979 (TTY: 711).

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711: (قم هاتف الصم والبكم.

Florida Community Care LLC
P.O. Box 261060
Miami, Florida 33126

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UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-997-0979 (TTY: 711).

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เรยน: ถา้ ารชจ่ ทางภาษาไดฟ รี โทร 1-888-997-0979 (TTY: 711).
คุณพูดภาษาไทยคุณสามารถใชบรก ยเหลอ

Florida Community Care LLC
P.O. Box 261060
Miami, Florida 33126

PLAN ID:

WRITTEN REQUEST TO APPEAL

Date:	
Enrollee Name:	
Address:	
Member ID:	
Date of Notice of Adverse Benefit Determination Letter:	
Service Requested:	

☐ I do not agree with the decision of Florida Community Care for the service(s) requested. I want to appeal this decision.

Signature:	
Date:	

If you need help filling out forms, please call us. We can help with an interpreter that speaks your language. If you have questions, call us at 833-FCC-PLAN or 711 for TTY. For more information on your rights, review the Grievance and Appeal section in your Member Handbook. It can be found online at: www.fcchealthplan.com.

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U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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คุณพูดภาษาไทยคุณสามารถใชบรก ยเหลอ

Florida Community Care LLC
P.O. Box 261060
Miami, Florida 33126

REQUEST FOR CHANGE OF ADDRESS

(Please type or print clearly)

Name: _____

Date of Birth: _____

Phone Number (including area code): _____

Social Security #: _____

FCC Member Number: _____

PREVIOUS ADDRESS

Mailing Address: _____

City: _____ **State:** _____ **Zip Code:** _____

NEW ADDRESS

Mailing Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Date: _____

Signature: _____

Please mail this form to:
Florida Community Care, Inc
P.O. Box 261060
Miami, FL 33126

You have the right to get several kinds of information from us. You have the right to get information from us in a way that works for you. Interpretation services and alternative format communications, such as Braille, are available to those with a vision and/or hearing impairment. This includes getting the information in languages other than English and in large print or other formats.

Alternative format and foreign language materials are available for free. Call Member Services at 1-833-FCC- PLAN.

Spanish
Esta información está disponible gratis en otros idiomas. Por favor, póngase en contacto con nuestro número de Servicios para Miembros a 1-833-FCC-PLAN (1-833-322-7526 (TDD/TTY 711), de lunes a Viernes, de 8 a.m. a 8 p.m.

Haitian Creole
Enfòmasyon sa a disponib gratis nan lòt lang. Tanpri kontakte sèvis kliyantèl nou an nan nimewo 1-833-FCC-PLAN (1-833-322-7526 (TDD/TTY 711) soti lendi pou rive vandredi, depi 8è AM rive 8è PM.

French
Ces informations sont disponibles gratuitement dans d'autres langues. Veuillez-vous adresser à notre service à la clientèle au 1-833-FCC-PLAN (1-833-322-7526) (ATS/TTY 711) entre 08 h et 20 h

Italian
Queste informazioni sono disponibili gratuitamente in altre lingue. Contattare il nostro Servizio Clienti al numero 1-833-FCC-PLAN (1-833-322-7526) (TDD/TTY 711) fra le ore 8:00 e le ore 20:00

Russian
Эта информация доступна бесплатно на других языках. Звоните в сервисную службу по номеру 1-833-FCC-PLAN (1-833-322-7526) (TDD/TTY 711) с 8:00 до 20:00

Non-Discrimination Notice
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For more information or if you have concerns about discrimination or unfair treatment, call the Department of Health and Human Services' Office for Civil Rights at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. If you have a disability and need help with access to care, call Member Services at 1-833- FCC-PLAN. If you have a concern, such as a problem with wheelchair access, Member Services can help.